

3

TO HOSPITAL ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. It must be signed by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death by the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If Item 21 is marked or Item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

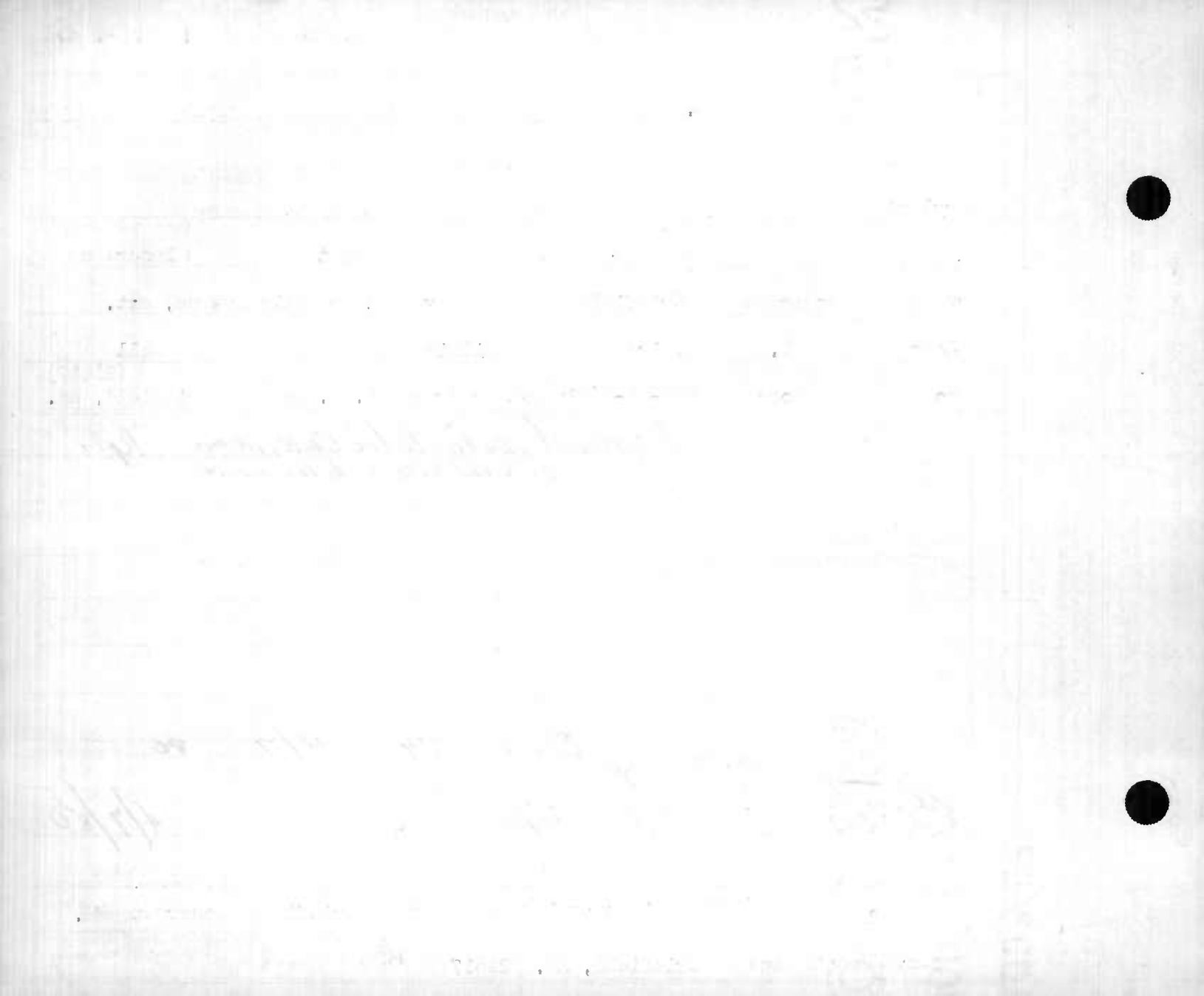
MEDICAL CERTIFICATION

ICAL CERTIFICAT

4

DHMH-16 20M
(VRA 15, 4) 7/78

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE									
CERTIFICATE OF DEATH									
REG. NO.									
1. DECEASED NAME <small>(TYPE OR PRINT)</small> FIRST MIDDLE LAST Fleeta L. ADAMS					2a. DATE OF DEATH MONTH DAY YEAR 4-7-80		2b. HOUR 1:45 PM		
3. SEX Female		4. RACE W		5. DATE OF BIRTH <small>MONTH DAY YEAR</small> 11-21-94		6. AGE (IN YEARS LAST BIRTHDAY) 85 YRS.		7. BALTIMORE CITY OR COUNTY OF DEATH Wicomico County MD	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Maryland		7b. CITIZEN OF WHAT COUNTRY? U.S.		8. MARITAL STATUS MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. USUAL OCCUPATION <small>(TYPE OF WORK FOR MOST OF WORKING LIFE)</small> Agent		10. KIND OF BUSINESS OR INDUSTRY Insurance	
10. CITY OR TOWN OF DEATH Salisbury		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION <small>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)</small> Salisbury Nursing Home				12a. USUAL RESIDENCE <small>(IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)</small> 13a. STATE 13b. COUNTY 13c. CITY OR TOWN Maryland Somerset Crisfield		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
14. FATHER'S NAME <small>FIRST MIDDLE LAST</small> John D. Laird					15. MOTHER'S MAIDEN NAME <small>FIRST MIDDLE LAST</small> Willie Bell				
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? <small>(YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES)</small> no none		16b. SOCIAL SECURITY NO. 277-24-2693		17. INFORMANT ADDRESS Pat McDorman P. O. Box 268 Crisfield, Md. (21817)					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1: DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>widespread metastatic carcinoma</u> <u>1991</u> DUE TO, OR AS A CONSEQUENCE OF <u>original site undetermined</u> . Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost: (b) _____ DUE TO, OR AS A CONSEQUENCE OF _____ (c) _____									
PART 2: OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: (a) _____									
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH <small>(IF EITHER, NOTIFY MEDICAL EXAMINER)</small>		21b. TIME OF INJURY <small>HOUR A.M. MONTH DAY YEAR</small> P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)					
21d. INJURY OCCURRED <small>WHILE AT WORK? <input type="checkbox"/> NOT WHILE AT WORK? <input type="checkbox"/></small>		21e. PLACE OF INJURY <small>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)</small>		21f. LOCATION <small>STREET CITY OR TOWN COUNTY STATE</small>		22. I certify that (I) (this hospital) attended the deceased from <u>8/22</u> , 19 <u>79</u> , to <u>4/7</u> , 19 <u>80</u> , that (I) (we) lost <u>saw the deceased alive on above date</u> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated <u>the body after death.</u>			
22b. SIGNATURE <i>[Signature]</i> DEGREE <u>MD</u>					22c. DATE SIGNED <u>4/7/80</u>			22d. ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>	
22e. PHYSICIAN'S NAME (TYPE OR PRINT) EARL M. BEARDSLEY, M.D.					22f. ADDRESS RT. 50 & CIVIC AVE., SALISBURY, Md. 21801				
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE 4/9/80		23c. NAME OF CEMETERY OR CREMATORY Sunnyridge Cemetery			23d. LOCATION <small>CITY OR TOWN COUNTY STATE</small> Crisfield Somerset Md.		
24. FUNERAL DIRECTOR <small>NAME ADDRESS</small> Bradshaw & Sons Crisfield, Md. 21817					25a. DATE REC'D. BY REGISTRAR APR 1 - 1980		25b. REGISTRAR'S SIGNATURE <i>[Signature]</i>		



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at 338-0302.

MEDICAL CERTIFICATION

FOR STATE REGISTRAR				STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH				REG. NO. 8011246			
1. DECEASED NAME (TYPE OR PRINT) Jean A. Anders				2a. DATE OF DEATH April 24 1980				2b. HOUR 4 P. M.			
3. SEX Female		4. RACE White		5. DATE OF BIRTH Nov. 11, 1923		6. AGE (IN YEARS LAST BIRTHDAY) 56 YRS.		7. IF UNDER 1 YEAR MONTHS DAYS		8. IF UNDER 24 HRS HOURS MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Maryland		7b. CITIZEN OF WHAT COUNTRY? USA		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Wicomico MD.					
10. CITY OR TOWN OF DEATH Salisbury		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Peninsula General Hospital				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Homemaker		12b. KIND OF BUSINESS OR INDUSTRY			
13a. STATE Maryland				13b. COUNTY Baltimore		13c. CITY OR TOWN Rodgers Forge		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET ADDRESS 7025 Heathfield Rd.	
14. FATHER'S NAME FIRST MIDDLE LAST William Klemm				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Rosalie LeGross							
16a. WAS DECEASED EVER IN U. S. ARMED FORCES? (YES, NO OR UNKNOWN) No				16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) 215-12-5744		17. INFORMANT ADDRESS Mrs. Valerie A. Schaefer 7 Devonshire Dr. Salisbury, Md.					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Hepatic and Renal Failure</u> <u>1749</u> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Breast Cancer</u> DUE TO, OR AS A CONSEQUENCE OF (c) _____										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) _____											
19a. DATE OF OPERATION				19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)					
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>				21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE					
22. I certify that (I) (the hospital) attended the deceased from <u>4/19</u> 19 <u>80</u> , to <u>4/24</u> 19 <u>80</u> , that (I) (we) last saw the deceased alive on <u>4/24</u> 19 <u>80</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.											
22a. SIGNATURE <u>Joseph A. Grasso</u>						DEGREE <u>MD</u>		ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <u>Joseph A. Grasso</u>						22e. ADDRESS					
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial				23b. DATE April 28, 1980		23c. NAME OF CEMETERY OR CREMATORY Parkwood		23d. LOCATION CITY OR TOWN COUNTY STATE Parkville, Balto. Co., Md.			
24. FUNERAL DIRECTOR NAME Mitchell-Wiedefeld Home, Inc.				ADDRESS 6500 York Rd. Balto., Md.		25a. DATE REC'D. BY REGISTRAR APR 30 1980		25b. REGISTRAR'S SIGNATURE <u>Anthony McCreedy</u>			

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IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH				REG. NO. 70 11247			
1. FOR STATE REGISTRAR				2a. DATE OF DEATH MONTH DAY YEAR 2b. HOUR			
1 DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST Lena T. ANDREWS				April 4, 1980 3:25 AM			
3. SEX Female		4. RACE White		5. DATE OF BIRTH MONTH DAY YEAR March 24 1911		6. AGE (IN YEARS LAST BIRTHDAY) YRS. MONTHS DAYS 69	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Maryland		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Wicomico MD.	
10. CITY OR TOWN OF DEATH Salisbury		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Deer's Head Center		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Worker		12b. KIND OF BUSINESS OR INDUSTRY Shellfish	
13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13b. STATE 13c. CITY OR TOWN Maryland Dorchester Cambridge				13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS 300 LeCompte Street	
14. FATHER'S NAME FIRST MIDDLE LAST Henry Washington Travers				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Annie Elizabeth Travers			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) no		16b. SOCIAL SECURITY NO. 212-12-3497		17. INFORMANT ADDRESS Mr. s Janice Lednum, Wittman, Md.			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>CVA with right hemisphere</u> 436- } DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____							APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) <u>Senile degeneration</u>							
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)			
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22a. I certify that (I) (this hospital) attended the deceased from _____, 19_____, to _____, 19_____, that (I) (we) last saw the deceased alive on _____, 19_____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.							
22b. SIGNATURE DEGREE <u>Ex Ritchings, MD</u> ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/>				22c. DATE SIGNED 4/4/80			
22d. PHYSICIAN'S NAME (TYPE OR PRINT) Edward P. Ritchings, M.D.				22e. ADDRESS Deer's Head Center; Salisbury, Md. 21801			
23a. BURIAL, CREMATION, REMOVAL Burial		23b. DATE 4-7-80		23c. NAME OF CEMETERY OR CREMATORY Dorchester Cem.		23d. LOCATION CITY OR TOWN COUNTY STATE Aireys, Dorchester, Md.	
24. FUNERAL DIRECTOR NAME Curran Funeral Home				25a. DATE REC'D. BY REGISTRAR APR 9 1980		25b. REGISTRAR'S SIGNATURE <u>Anthony Anthony</u>	

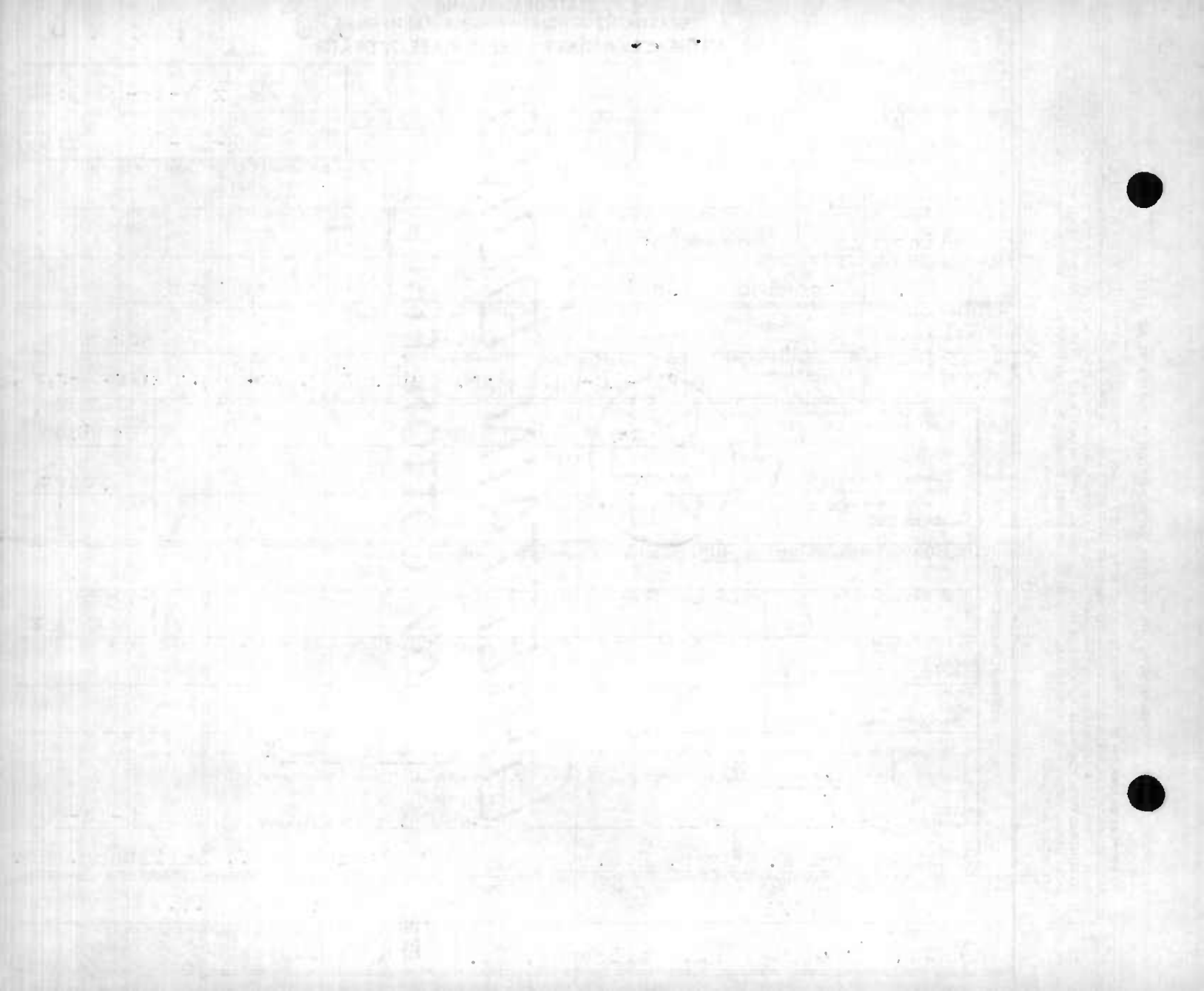
TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM. 3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED, WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

BP

DHMH - 17
(VR A15 ME (5))
30M 7/73

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

FOR 1- STATE REGISTRAR		REG. NO. 11248	
1. DECEASED NAME (TYPE OR PRINT)		FIRST MIDDLE LAST	
ADA Ellen ARVEY			
3 SEX	4 RACE	5. DATE OF BIRTH	6. AGE (IN YEARS)
Female	White	5 3 1888	91 YRS.
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)		7b. CITIZEN OF WHAT COUNTRY?	8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>
Hebron, Md.		USA	Baltimore City or County of Death
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)	12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)
Salisbury		Schumaker Lane	Housewife
13a. STATE		13b. COUNTY	13c. CITY OR TOWN
Md.		Wicomico	Salisbury
14. FATHER'S NAME		15. MOTHER'S MAIDEN NAME	
FIRST MIDDLE LAST Clayton H. Mills		FIRST MIDDLE LAST Matilda Wilson	
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN)		16b. SOCIAL SECURITY NO.	17 INFORMANT (daughter) ADDRESS
No		214-10-9481	Mrs. Rebecca C. Greeby, Reisterstown, Md.
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)			APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Coronary Occlusion			sudden
Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last.			years
(b) ASCVD			
(c) DUE TO, OR AS A CONSEQUENCE OF			
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a).			
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?	
21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)	
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)	
22a. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/> .			
ACTUAL SIGNATURE		TITLE (SPECIFY)	
Earl L. Royer, M.D.		Deputy MEDICAL EXAMINER	
EXAMINER'S NAME (TYPE OR PRINT)		DATE SIGNED	
		4-14-80	
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)		23b. DATE	
Burial		4/16/80	
23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION	
Parsons Cemetery		Salisbury, Wic., Maryland	
24. FUNERAL DIRECTOR NAME		25a. DATE REC'D. BY REGISTRAR	
HOLLOWAY FUNERAL HOME, Salisbury, Md.		APR 17 1980	
25b. REGISTRAR'S SIGNATURE			



TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM-3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL-TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED, WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

BP

DHMH - 17
(VR A15 ME (5))
30M 7/73

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO.

1- FOR
STATE
REGISTRAR

1. DECEASED NAME (TYPE OR PRINT)		FIRST		MIDDLE		LAST		2a. DATE KNOWN OF DEATH		ESTIMATED		MONTH		DAY		YEAR		7b. HOUR	
ERNEST WASHINGTON BAILEY								4-12-80		10A									
3. SEX	4. RACE	5. DATE OF BIRTH		6. AGE (IN YEARS)		IF UNDER 1 YR.		IF UNDER 24 HRS.		7c. DATE PRONOUNCED DEAD		MONTH		DAY		YEAR		7d. HOUR	
Male	White	10 13 06		73 YRS						4-12-80		19		10		40A			
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED		NEVER MARRIED		9. BALTIMORE CITY OR COUNTY OF DEATH										MD.	
Maryland		USA		WIDOWED		DIVORCED		Wicomico											
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		12b. KIND OF BUSINESS OR INDUSTRY													
Sharptown		near St. Rt. 348		Inspector		Elec.													
13a. STATE		13b. COUNTY		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS?		13e. STREET ADDRESS											
Md.		Wicomico		Sharptown		YES <input type="checkbox"/> NO <input type="checkbox"/>		102 4th St.											
14. FATHER'S NAME		15. MOTHER'S MAIDEN NAME																	
Ernest Bailey		Milton Wright Bailey																	
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN)		16b. SOCIAL SECURITY NO.		17. INFORMANT		ADDRESS													
No		220-03-2017		Margaret Bailey		Sharptown, Md.													
18. CAUSE OF DEATH (Enter only one cause per line for (d), (b), and (c).) PART 1 DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Coronary Occlusion</u> 410- Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last. (b) <u>ASCVD</u> (c) <u></u> APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <u>sudden</u> <u>years</u>																			
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a).																			
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?										20. AUTOPSY?							
												YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)															
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)		21f. LOCATION STREET		CITY OR TOWN		COUNTY		STATE									
22a. I certify that I took charge of the remains described above, held on Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and in my opinion death resulted from: <u>Natural causes</u> <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/> .																			
ACTUAL SIGNATURE		TITLE (SPECIFY)		DATE SIGNED															
<u>Earl L. Royer, M.D.</u>		M.D. Deputy		MEDICAL EXAMINER		4-14-80													
EXAMINER'S NAME (TYPE OR PRINT)		ADDRESS		409 Camden Ave., Salisbury, Md.															
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION CITY OR TOWN		COUNTY		STATE									
Burial		4-15-80		Firemen's Cemetery		Sharptown, Md.													
24. FUNERAL DIRECTOR NAME		ADDRESS		25a. DATE REC'D. BY REGISTRAR		25b. REGISTRAR'S SIGNATURE													
Ullrich Funeral Home, Berlin, Md.				APR 21 1980		<u>Earl L. Royer</u>													

St. Louis, Mo. 63101

- 1 -

243

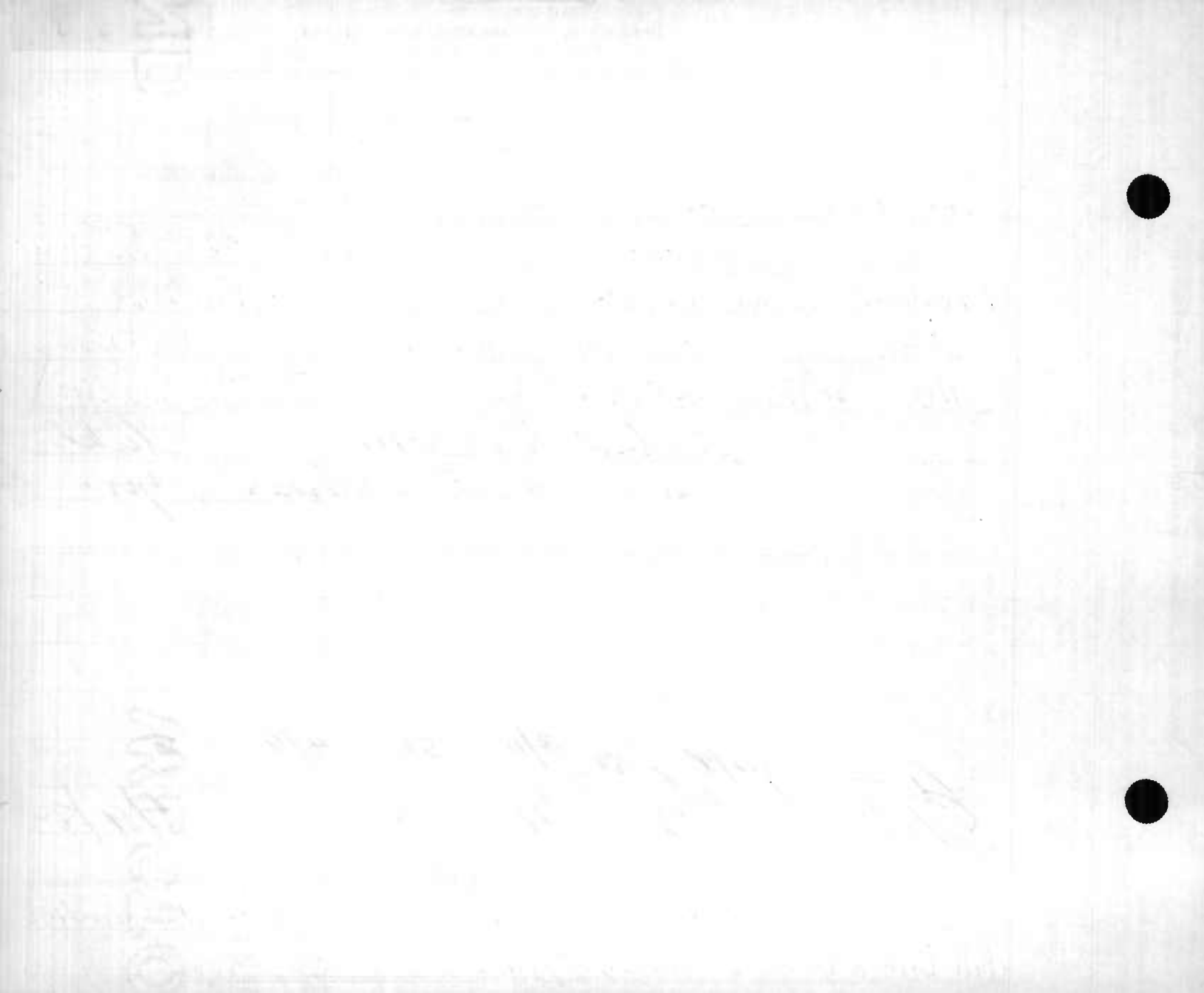
TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified of once.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE										8 0 1 1 2 5 0	
1. FOR STATE REGISTRAR				CERTIFICATE OF DEATH				REG. NO.			
1. DECEASED NAME (TYPE OR PRINT) Manilla E. BEACHAMP				2a. DATE OF DEATH MONTH DAY YEAR 4-9-80				2b. HOUR 7:15A _M			
3. SEX F		4. RACE W		5. DATE OF BIRTH MONTH DAY YEAR 3-10-98		6. AGE (IN YEARS LAST BIRTHDAY) 82 YRS		7. IF UNDER 1 YEAR MONTHS DAYS		8. IF UNDER 24 HRS HOURS MIN	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) MARYLAND		7b. CITIZEN OF WHAT COUNTRY? U.S.		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Wicomico County MD.					
10. CITY OR TOWN OF DEATH Salisbury		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Salisbury Nursing Home						12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Housewife		12b. KIND OF BUSINESS OR INDUSTRY OWN Home	
13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE MARYLAND				13b. COUNTY WICOMICO		13c. CITY OR TOWN Salisbury		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS 501 N. Div. St.	
14. FATHER'S NAME FIRST MIDDLE LAST John Riggan				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST MARY UNKNOWN							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) NO				16b. SOCIAL SECURITY NO. (IF YES, GIVE YEAR OR DATES) NO		17. INFORMANT ADDRESS FRANCES Wilmen 501 N. Div. St. Salisbury, MD 21801					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cerebral thrombosis</u> 4340 DUE TO, OR AS A CONSEQUENCE OF: (b) <u>Generalized arteriosclerosis</u> DUE TO, OR AS A CONSEQUENCE OF: (c) <u></u>										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 1 wk. yes.	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a)											
19a. DATE OF OPERATION				19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)					
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>				21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE					
22. I certify that (I) (this hospital) attended the deceased from <u>3/11</u> 19 <u>80</u> , to <u>4/9</u> 19 <u>80</u> , that (I) (we) lost saw the deceased alive on <u>4/8</u> 19 <u>80</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (If we did not view the body after death, so state.)											
23. SIGNATURE <u>Earl M. Beardsley</u> DEGREE M.D.						24. ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		25. DATE SIGNED 4/9/80			
26. PHYSICIAN'S NAME (TYPE OR PRINT) EARL M. BEARDSLEY, M.D.						27. ADDRESS RT. 50 & CIVIC AVE, SALISBURY, MD.					
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) BURIAL		23b. DATE 4/11/1980		23c. NAME OF CEMETERY OR CREMATORY Wic. Mem. Park		23d. LOCATION CITY OR TOWN COUNTY STATE Salisbury Wicomico MD					
24. FUNERAL DIRECTOR NAME Hill-Baker-Bounds						25a. DATE REC'D. BY REGISTRAR APR 14 1980		25b. REGISTRAR'S SIGNATURE <u>Anthony McCreedy</u>			

BP



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If Item 21 is marked or Item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

Item 15 8545 7/3/80 gj

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

8 0 1 1 2 5 1

FOR
1 - STATE
REGISTRAR

REG. NO.

1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST <i>Frances W. BEEBE</i>			2a. DATE OF DEATH MONTH DAY YEAR <i>APRIL 8, 1980</i>			2b. HOUR <i>12:00</i> M				
3. SEX <i>Female</i>		4. RACE <i>White</i>		5. DATE OF BIRTH MONTH DAY YEAR <i>1-24-1910</i>		6. AGE (IN YEARS LAST BIRTHDAY) <i>70</i> YRS.		7. IF UNDER 1 YEAR MONTHS DAYS HOURS MIN <i>None</i>		
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <i>Virginia</i>		7b. CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i>		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <i>Wicomico</i> MD.				
10. CITY OR TOWN OF DEATH <i>Salisbury</i>		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <i>Peninsula General Hospital</i>				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <i>Housewife</i>		12b. KIND OF BUSINESS OR INDUSTRY <i>None</i>		
USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)										
13a. STATE <i>Va</i>		13b. COUNTY <i>Accomack</i>		13c. CITY OR TOWN <i>Chincoteague</i>		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS <i>Church Street</i>		
14. FATHER'S NAME FIRST MIDDLE LAST <i>Archie Wimbrow</i>					15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <i>Rebecca Lou Reynolds</i>					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <i>NO</i>		16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) <i>227-64-8978</i>		17. INFORMANT ADDRESS <i>Ronald Beebe, Snow Hill, Md</i>						
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY. IMMEDIATE CAUSE (a) <i>Refractory Ventricular Fibr.</i> <i>4/14/80</i> DUE TO, OR AS A CONSEQUENCE OF (b) <i>coronary artery disease</i> DUE TO, OR AS A CONSEQUENCE OF (c) <i>arteriosclerosis</i>								APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <i>3-5 yr</i> <i>10 yr</i>		
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a)										
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)				
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)			21f. LOCATION STREET CITY OR TOWN COUNTY STATE				
22a. I certify that (I) (this hospital) attended the deceased from <i>12</i> , 19 <i>79</i> , to <i>4</i> , 19 <i>80</i> , that (I) (we) lost saw the deceased alive on <i>4/18/80</i> 19 <i>80</i> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.										
22b. SIGNATURE <i>J. L. Raffetto</i>			DEGREE			ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>			22c. DATE SIGNED <i>4-8/80</i>	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <i>J. L. RAFFETTO</i>					22e. ADDRESS <i>PGH</i>					
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <i>Burial</i>			23b. DATE <i>4-11-1980</i>		23c. NAME OF CEMETERY OR CREMATORY <i>Taylor's Memorial</i>		23d. LOCATION CITY OR TOWN COUNTY STATE <i>Temperanceville, Accomack Co. VA</i>			
24. FUNERAL DIRECTOR NAME <i>Wick</i>					ADDRESS <i>Temperanceville, VA 23442</i>		25a. DATE REC'D. BY REGISTRAR <i>APR 16 1980</i>		25b. REGISTRAR'S SIGNATURE <i>[Signature]</i>	

Item 2a g545 7/3/80 gj

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

8 0

1 1 2 5 2

FOR
1. STATE
REGISTRAR

REG. NO.

1. DECEASED NAME (TYPE OR PRINT) Della ^{FIRST} T. ^{MIDDLE} BENNETT ^{LAST}			2a. DATE OF DEATH MONTH APRIL DAY 17 YEAR 1980		2b. HOUR 12 30 ^{PM}
3 SEX Female	4 RACE White	5. DATE OF BIRTH MONTH 6 DAY 13 YEAR 09	6 AGE (IN YEARS LAST BIRTHDAY) 70 YRS.	IF UNDER 1 YEAR MONTHS DAYS HOURS MIN	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Tennessee	7b. CITIZEN OF WHAT COUNTRY? US	MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	9. BALTIMORE CITY OR COUNTY OF DEATH Wicomico MD.		
10 CITY OR TOWN OF DEATH Salisbury	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Peninsula General Hospital		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) At Home		12b. KIND OF BUSINESS OR INDUSTRY
USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE Md. 13b. COUNTY Wic. 13c. CITY OR TOWN Sharptown			13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	13e. STREET ADDRESS 606 Main Street	
14 FATHER'S NAME ^{FIRST} Fred ^{MIDDLE} Terry ^{LAST}			15. MOTHER'S MAIDEN NAME ^{FIRST} Nellie ^{MIDDLE} Terry ^{LAST}		
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) No	16b. SOCIAL SECURITY NO. 8083-26-9823	17. INFORMANT ADDRESS James Bennett Sharptown, Md.			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cardiac failure 4254 DUE TO, OR AS A CONSEQUENCE OF (b) ischemic cardiomyopathy DUE TO, OR AS A CONSEQUENCE OF (c) arteriosclerosis					APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 15 min 5.30 10.30
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)					
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>	20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)	
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE	
22a. I certify that (I) (this hospital) attended the deceased from 6/79 19 79 , to 4-13 19 80 , that (I) (we) lost saw the deceased alive on 4-13 19 80 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.					
22b. SIGNATURE SGE 1/4 17		DEGREE		22c. DATE SIGNED 4/14/80	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) RAFAEL		22e. ADDRESS CGX			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE 4-16-80	23c. NAME OF CEMETERY OR CREMATORY Spring Hill Memory Cds.		23d. LOCATION CITY OR TOWN COUNTY STATE Salisbury, Wic., Md.
24. FUNERAL DIRECTOR Ulbrich Funeral Home		ADDRESS Sharptown, Md.		25a. DATE REC'D. BY REGISTRAR APR 21 1980	
				25b. REGISTRAR'S SIGNATURE Dorothy McCreary	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Please may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon copies. Pages 1 and 2 should be filed within 22 hours after death, with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

BP _____

Female	White	1-1-02	70
Tennessee	Don	xx	100-100
St. Mary	Porter and Porter Hospital	xx	100-100
Pa.	St. James	xx	100-100
Mass. Town	St. James	xx	100-100
Pa.	100-100-100	xx	100-100

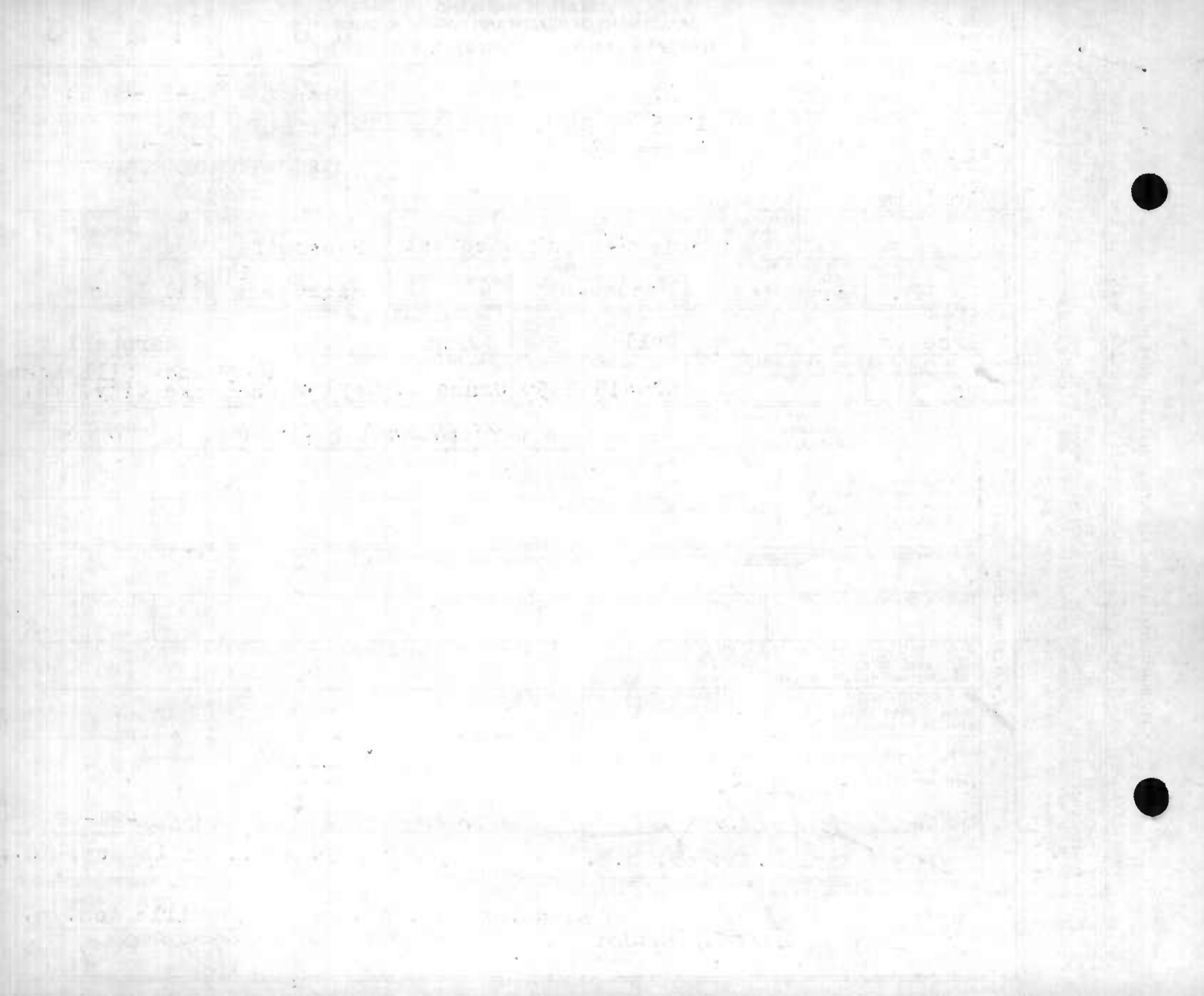
White female 100-100-100
1-1-02 100-100-100

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED, WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

BP
DHMH - 17
(VR 15 ME (5))
30M 7/73

FOR 1- STATE REGISTRAR										STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE MEDICAL EXAMINER'S CERTIFICATE OF DEATH										8011253 REG. NO.			
1. DECEASED NAME (TYPE OR PRINT)			FIRST		MIDDLE		LAST			2a. DATE KNOWN OF DEATH			MONTH		DAY		YEAR		2b. HOUR				
JANIE			B.		BLOXOM			4-28-80			9		50A										
3. SEX		4. RACE		5. DATE OF BIRTH		6. AGE IN YEARS		IF UNDER 1 YR.		IF UNDER 24 HRS.		7c. DATE PRONOUNCED DEAD			MONTH		DAY		YEAR		2d. HOUR		
Female		White		8 5 1896		83						4-28-80			11								
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)				7b. CITIZEN OF WHAT COUNTRY?				8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>				9. BALTIMORE CITY OR COUNTY OF DEATH				MD.							
Virginia				USA				WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>				Wicomico											
10. CITY OR TOWN OF DEATH				11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)								12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)				12b. KIND OF BUSINESS OR INDUSTRY							
Salisbury				Peninsula General Hospital								housewife											
13a. STATE				13b. COUNTY		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS?		13e. STREET ADDRESS													
Md.				Worcester		Pocomoke		YES <input type="checkbox"/> NO <input type="checkbox"/>		1405		1405 Snow Hill Lane											
14. FATHER'S NAME				15. MOTHER'S MAIDEN NAME																			
Arcemus				Bull		Anna				Marshall													
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN)				16b. SOCIAL SECURITY NO.				17. INFORMANT				ADDRESS											
no				224-18-2350				Grace B. Taylor				1405 Snow Hill Lane Pocomoke City, Md.											
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)																							
PART I DEATH WAS CAUSED BY: <u>Hypertensive Cardiovascular Disease</u>																							
4029 IMMEDIATE CAUSE (a) <u>Hypertensive Cardiovascular Disease</u>																							
DUE TO, OR AS A CONSEQUENCE OF																							
(b) <u>Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last.</u>																							
DUE TO, OR AS A CONSEQUENCE OF																							
(c)																							
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a).																							
19a. DATE OF OPERATION				19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?										20. AUTOPSY?									
														YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>									
21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH				21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19				21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)															
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>				21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)				21f. LOCATION STREET CITY OR TOWN COUNTY STATE															
22a. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> .																							
ACTUAL SIGNATURE				TITLE (SPECIFY)				DATE SIGNED															
<i>Earl L. Royer</i>				M.D. Deputy				MEDICAL EXAMINER				4-29-80											
EXAMINER'S NAME (TYPE OR PRINT)				ADDRESS																			
Earl L. Royer, M.D.				409 Camden Ave., Salisbury, Md.																			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)				23b. DATE		23c. NAME OF CEMETERY OR CREMATORY				23d. LOCATION CITY OR TOWN COUNTY STATE													
Burial				4/30/80		John M. Taylor Mem. Cem.				Temperanceville Acc. Va.													
24. FUNERAL DIRECTOR NAME				25a. DATE RECD. BY REGISTRAR				25b. REGISTRAR'S SIGNATURE															
Watson Funeral Home, Pocomoke, Md.				MAY 3 1980				<i>Earl L. Royer</i>															

MEDICAL CERTIFICATION



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

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MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE										8 0 1 1 2 5 4	
1. FOR STATE REGISTRAR					CERTIFICATE OF DEATH					REG. NO.	
1. DECEASED NAME (TYPE OR PRINT) Samuel O. BOWERS, JR.					2a. DATE OF DEATH MONTH DAY YEAR April 27, 1980					2b. HOUR 1:45a.m.	
3. SEX male		4. RACE cau.		5. DATE OF BIRTH MONTH DAY YEAR Sept. 15, 1902			6. AGE (IN YEARS LAST BIRTHDAY) 77		IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS. HOURS MIN.		
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Maryland		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>			9. BALTIMORE CITY OR COUNTY OF DEATH Wicomico MD.				
10. CITY OR TOWN OF DEATH Salisbury		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Deer's Head Center					12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Wire Drawer		12b. KIND OF BUSINESS OR INDUSTRY Steel Mfg.		
USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)					13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET ADDRESS rural				
13a. STATE Maryland		13b. COUNTY Dor.		13c. CITY OR TOWN Crapo							
14. FATHER'S NAME FIRST MIDDLE LAST Samuel Bowers					15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Ella Leach						
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) no		16b. SOCIAL SECURITY NO. 213-07-9866		17. INFORMANT ADDRESS Mrs. Georgia Bowers, Crapo, Md. 21626							
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Metastatic carcinoma (primary site unknown) 1991 DUE TO, OR AS A CONSEQUENCE OF (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) Coronary heart failure											
19a. DATE OF OPERATION 4/27/80			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED Coronary heart failure				20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)					
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)			21f. LOCATION STREET CITY OR TOWN COUNTY STATE					
22a. I certify that (I) (this hospital) attended the deceased from _____, 19_____, to _____, 19_____, that (I) (we) lost saw the deceased alive on _____, 19_____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.											
22b. SIGNATURE E. P. Ritchings, M.D.					DEGREE ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/>					22c. DATE SIGNED 4/27/80	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) E. P. RITCHINGS, M. D.					22e. ADDRESS Deer's Head Center, Salisbury, Md. 21801						
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) burial			23b. DATE 4/27/1980		23c. NAME OF CEMETERY OR CREMATORY Oaklawn Cem.			23d. LOCATION CITY OR TOWN COUNTY STATE Balto. Md.			
24. FUNERAL DIRECTOR NAME Curran Funeral Home, 308 High St., Cambridge, Md.					25a. DATE REC'D. BY REGISTRAR MAY 2 1980		25b. REGISTRAR'S SIGNATURE [Signature]				

• 07-04

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbonpapers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified by name.

1. FOR
STATE
REGISTRAR

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

1. DECEASED NAME (TYPE OR PRINT) Margaret Elizabeth BOZMAN			2a. DATE OF DEATH MONTH DAY YEAR 4-16-80		2b. HOUR 6:10PM
3. SEX F	4. RACE W	5. DATE OF BIRTH MONTH DAY YEAR 10-2-89	6. AGE (IN YEARS LAST BIRTHDAY) 90 YRS	7. IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS HOURS MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Deal Island, Md.	7b. CITIZEN OF WHAT COUNTRY? U.S.	8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	9. BALTIMORE CITY OR COUNTY OF DEATH Wicomico County MD.		
10. CITY OR TOWN OF DEATH Salisbury	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Salisbury Nursing Home		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Teacher	12b. KIND OF BUSINESS OR INDUSTRY Public School	
13a. STATE Maryland		13b. COUNTY Wicomico	13c. CITY OR TOWN Salisbury	13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>	13e. STREET ADDRESS 731 Camden Ave.
14. FATHER'S NAME FIRST MIDDLE LAST James A. Anderson		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Sarah Wilson			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) NO		16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES)		17. INFORMANT ADDRESS 124 E. Main St. Mr. J. William Long, Salisbury, Md.	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cerebral Thrombosis</u> 4340 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last: (b) <u>Generalized arteriosclerosis</u> (c) <u></u> DUE TO, OR AS A CONSEQUENCE OF APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <u>1 wk.</u> <u>yes</u>					
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)					
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>	20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)	
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE	
22a. I certify that (I) (this hospital) attended the deceased from <u>9/16</u> , 19 <u>69</u> , to <u>4/16</u> , 19 <u>80</u> , that (I) (we) last saw the deceased alive on <u>4/15</u> , 19 <u>80</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (If I (we) did not see the body after death, so state.)					
22b. SIGNATURE <u>Earl M. Beardsley</u> PHYSICIAN'S NAME (TYPE OR PRINT)		DEGREE <u>MD</u> ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED <u>4/17/80</u>	
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE 4/21/80		23c. NAME OF CEMETERY OR CREMATORY St. Johns Church Cem. Deal Island, Som., Md.	
24. FUNERAL DIRECTOR NAME HOLLOWAY FUNERAL HOME, Salisbury, Md.		ADDRESS Rt. 50 & Civic Ave Salisbury, Md. 21801		25a. DATE REC'D. BY REGISTRAR APR 21 1980	
25b. REGISTRAR'S SIGNATURE <u>Anthony McCready</u>					



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 42 hours of death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If Item 21 is marked or Item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE 8 0 1 1 2 5 6 CERTIFICATE OF DEATH													
1. FOR STATE REGISTRAR			REG. NO.										
1 DECEASED NAME (TYPE OR PRINT)			2a DATE OF DEATH			MONTH		DAY		YEAR		2b HOUR	
PRESLEY V. BOZMAN			APRIL 26		1980		10		45		AM		
3 SEX		4 RACE		5 DATE OF BIRTH		6 AGE (IN YEARS LAST BIRTHDAY)		IF UNDER 1 YEAR		IF UNDER 24 HRS			
M.		W.		FEB. 25 1893		87		MONTHS		DAYS			
7a BIRTHPLACE (STATE OR FOREIGN COUNTRY)		7b CITIZEN OF WHAT COUNTRY?		8 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9 BALTIMORE CITY OR COUNTY OF DEATH							
MD.		U.S.A.				Wicomico MD.							
10 CITY OR TOWN OF DEATH			11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)			12a USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)			12b KIND OF BUSINESS OR INDUSTRY				
Salisbury			Peninsula General Hospital			WATERMAN			SEA FOOD				
13a STATE			13b COUNTY		13c CITY OR TOWN		13d INSIDE CITY LIMITS?		13e STREET ADDRESS				
MD.			Som.		PRINCESS ANNE		YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		CRISTFIELD LANE				
14 FATHER'S NAME			15. MOTHER'S MAIDEN NAME			16a WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)			16b SOCIAL SECURITY NO.				
VAUGHN			FLORENCE SHORES			NO			218-14-1828				
17 INFORMANT			ADDRESS			18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY. IMMEDIATE CAUSE (a) <i>Operation pneumonia</i>			APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH				
ETHEL MARRINER			Box 74 PRINCESS ANNE MD						48 hrs.				
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) <i>Arteriosclerotic peripheral vascular disease and gangrene of both toe</i>													
19a DATE OF OPERATION			19b CONDITION FOR WHICH OPERATION WAS PERFORMED			20a AUTOPSY?		20b IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?					
						YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		YES <input type="checkbox"/> NO <input type="checkbox"/>					
21a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b TIME OF INJURY			21c HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)							
			HOUR A.M. MONTH DAY YEAR										
21d INJURY OCCURRED			21e PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)			21f LOCATION							
WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK						CITY OR TOWN COUNTY STATE							
22a I certify that (I) (this hospital) attended the deceased from 4/16 1980, to 4/26 1980, that (I) (we) last saw the deceased alive on 4/16 1980, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.													
22b SIGNATURE			DEGREE			22c DATE SIGNED							
Michael P. Buchness			ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>			4/26/80							
22d PHYSICIAN'S NAME (TYPE OR PRINT)			22e ADDRESS			22f DATE REC'D. BY REGISTRAR							
Michael P. Buchness			Suite 25 Salisbury - MD. Medical Center West.			MAY 5 1980							
23a BURIAL, CREMATION, REMOVAL (SPECIFY)			23b DATE		23c NAME OF CEMETERY OR CREMATORY		23d LOCATION		COUNTY		STATE		
BURIAL			4/29/80		BEECHWOOD CEM.		PR. ANNE		Som.		MD.		
24 FUNERAL DIRECTOR			ADDRESS			25a DATE REC'D. BY REGISTRAR			25b REGISTRAR'S SIGNATURE				
Leroy Webster			R.3 Box 354 PRINCESS ANNE, MD.			MAY 5 1980			Lester McCreedy				

BP

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH, IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL-TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED, WITH PAGES 3 AND 4, AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

BP

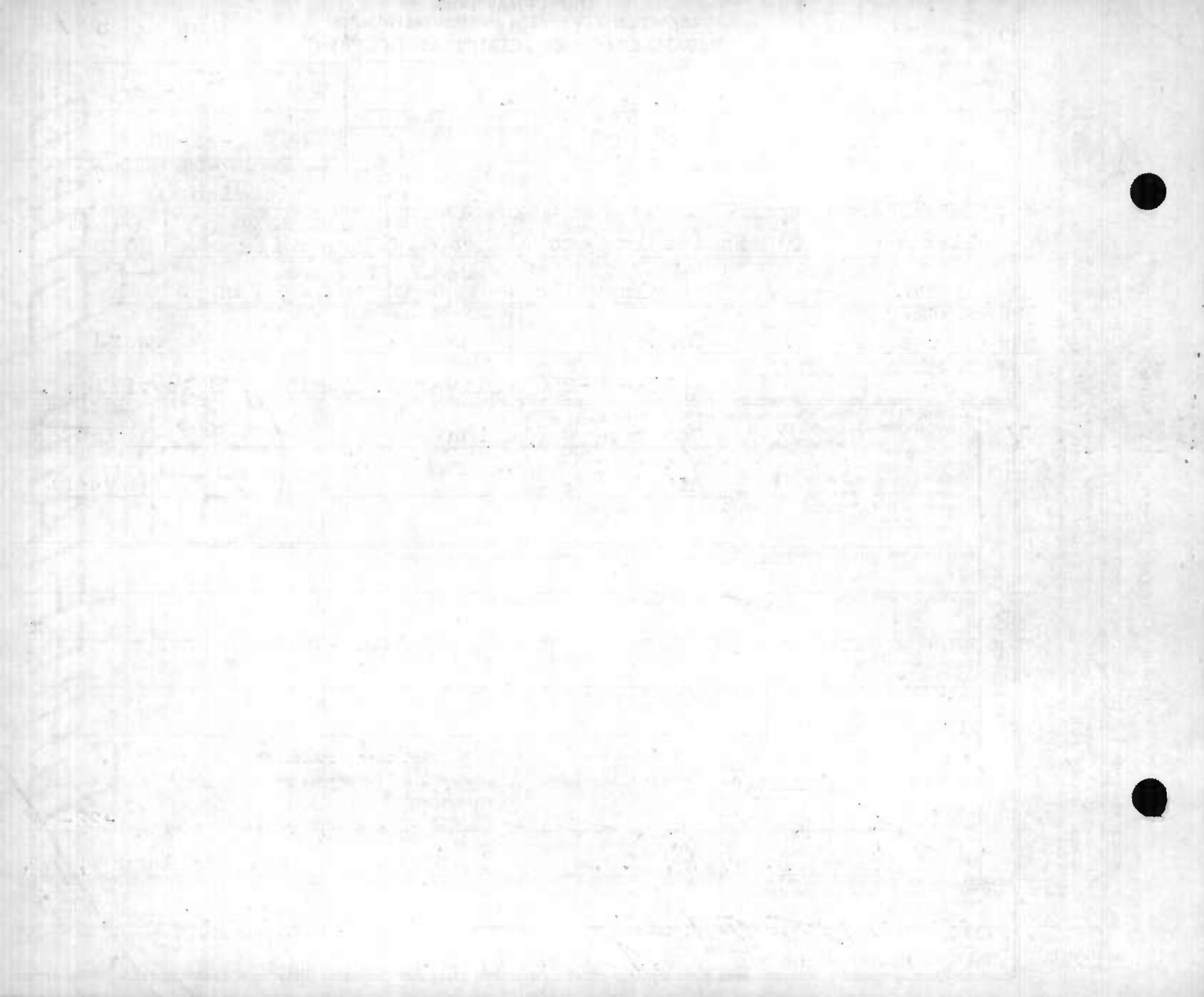
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STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO.

FOR
1- STATE
REGISTRAR

1. DECEASED NAME (TYPE OR PRINT)		FIRST		MIDDLE		LAST		2a. DATE KNOWN OF DEATH		MONTH		DAY		YEAR		2b. HOUR	
FLORENCE A. BUNTING								4-21-80		4		21		80		5:16P	
3. SEX	4. RACE	5. DATE OF BIRTH		6. AGE (IN YEARS)		IF UNDER 1 YR.		IF UNDER 24 HRS.		2c. DATE PRONOUNCED DEAD		MONTH		DAY		YEAR	
Female	White	6 12 01		78						4-21-80		4		21		80	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED		NEVER MARRIED		9. BALTIMORE CITY OR COUNTY OF DEATH									
Delaware		USA		WIDOWED		X NEVER MARRIED		Wicomico									
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		12b. KIND OF BUSINESS OR INDUSTRY											
Salisbury		DOA Peninsula General Hospital		Housewife		Home											
13a. STATE		13b. COUNTY		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS?		13e. STREET ADDRESS									
De.		Sussex		Selbyville		YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		Rt. 2, Box 58									
14. FATHER'S NAME		15. MOTHER'S MAIDEN NAME															
George E. Townsend		Amanda Howard															
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN)		16b. SOCIAL SECURITY NO.		17. INFORMANT		ADDRESS											
No		221-50-2593		Oliver W. Bunting, Selbyville, DE													
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I DEATH WAS CAUSED BY:		IMMEDIATE CAUSE (a)		Coronary Occlusion		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH		minutes									
		(b)		ASCVD		years											
		(c)															
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a).																	
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?		20. AUTOPSY?		YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>											
21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)													
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE													
22a. I certify that I took charge of the remains described above, held an		Autopsy <input type="checkbox"/>		Inspection <input checked="" type="checkbox"/>		Inquiry <input checked="" type="checkbox"/>		and in my opinion									
death resulted from:		Natural causes <input checked="" type="checkbox"/>		Accident <input type="checkbox"/>		Suicide <input type="checkbox"/>		Homicide <input type="checkbox"/>		Undetermined manner <input type="checkbox"/>							
ACTUAL SIGNATURE		TITLE (SPECIFY)		DATE SIGNED		4-22-80											
EXAMINER'S NAME (TYPE OR PRINT)		Earl L. Royer, M.D.		ADDRESS		409 Camden Ave., Salisbury, Md.											
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION CITY OR TOWN COUNTY STATE											
Burial		4-25-80		St. George's Cem.		Clarksville, Sussex, DE											
24. FUNERAL DIRECTOR NAME		25a. DATE REC'D. BY REGISTRAR		25b. REGISTRAR'S SIGNATURE													
Pete Whaley Funeral Home, Selbyville, De.		APR 30 1980		Pete Whaley													



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbonpapers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

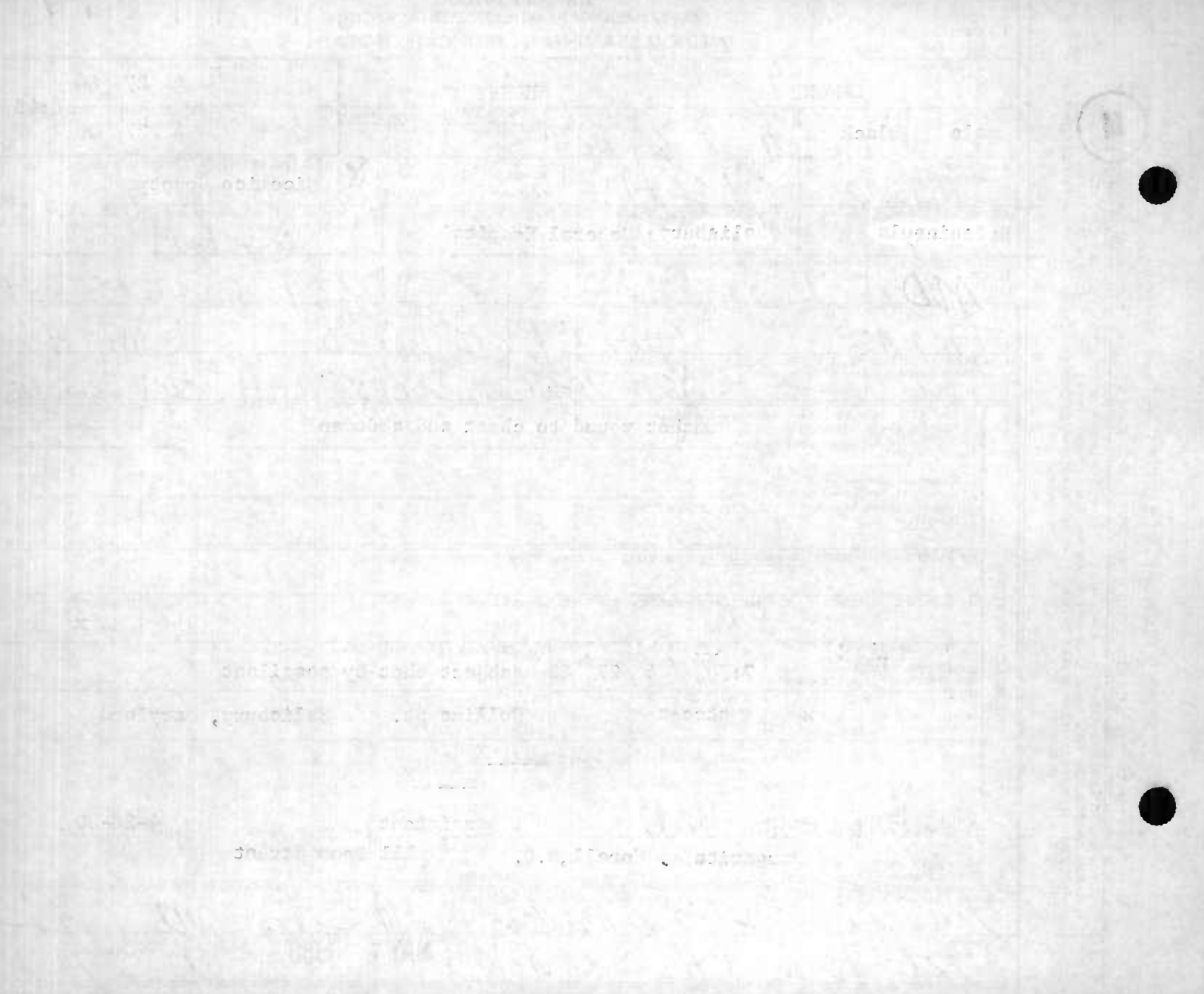
IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.



STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE				8 0 1 1 2 5 8			
1. FOR STATE REGISTRAR				CERTIFICATE OF DEATH			
1. DECEASED NAME (TYPE OR PRINT)				2a. DATE OF DEATH			
FIRST MIDDLE LAST Idetta E. CHAMBERS				MONTH DAY YEAR April 21, 1980			
3. SEX FEMALE		4. RACE WHITE		5. DATE OF BIRTH MONTH DAY YEAR 4 23 1919		6. AGE (IN YEARS LAST BIRTHDAY) 60 YRS.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) DELAWARE		7b. CITIZEN OF WHAT COUNTRY? USA		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Wicomico MD.	
10. CITY OR TOWN OF DEATH Salisbury		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Deer's Head Center		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) HOUSEWIFE		12b. KIND OF BUSINESS OR INDUSTRY	
13a. STATE MARYLAND				13b. COUNTY WORCESTER		13c. CITY OR TOWN WHALEYSVILLE	
14. FATHER'S NAME FIRST MIDDLE LAST LEWES D. MARVEL				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST MARY S. MARVEL			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) NO		16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) 218-16-5721		17. INFORMANT ADDRESS WAYNE L. CHAMBERS WHALEYSVILLE, MD.			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) ASCVD with CHF 4292 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO, OR AS A CONSEQUENCE OF (b) DUE TO, OR AS A CONSEQUENCE OF (c)							APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH yrs
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) COPD, anemia, diabetes mellitus, Prerenal azotemia							
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)			
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22a. I certify that (I) (this hospital) attended the deceased from _____, 19_____, to _____, 19_____, that (I) (we) last saw the deceased alive on _____, 19_____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.							
22b. SIGNATURE Nancy W. Tustin, M.D.				DEGREE ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/>		22c. DATE SIGNED	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) Nancy W. Tustin, M.D.				22e. ADDRESS Deer's Head Center; Salisbury, Md. 21801			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) BURIAL		23b. DATE 4-23-80		23c. NAME OF CEMETERY OR CREMATORY LINE CEMETERY		23d. LOCATION CITY OR TOWN COUNTY STATE WHITESVILLE, SUSSEX, DEL.	
24. FUNERAL DIRECTOR William J. Searns				25a. DATE REC'D. BY REGISTRAR APR 23 1980		25b. REGISTRAR'S SIGNATURE [Signature]	

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, THE MEDICAL EXAMINER SHOULD EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. GIVE PAGE 4 TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM-3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL-TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED, WITHIN 48 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE MEDICAL EXAMINER'S CERTIFICATE OF DEATH										REG. NO. 0 1 1 2 5 9	
1. FOR STATE REGISTRAR		FIRST MIDDLE LAST LAMONT CHANEY						2a. DATE KNOWN OF DEATH ESTIMATED		MONTH DAY YEAR 4 27 80	
3. SEX male		4. RACE black		5. DATE OF BIRTH MONTH DAY YEAR 4 8 60		6. AGE (IN YEARS) LAST BIRTHDAY 20 YRS.		IF UNDER 1 YR. MONTHS DAYS HOURS MIN.		2b. DATE PRONOUNCED DEAD MONTH DAY YEAR 4 27 80	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) MD.		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Wicomico County MD.					
10. CITY OR TOWN OF DEATH Salisbury		11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT HOME STREET ADDRESS) Peniculus General Hospital						12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Hospital		12b. KIND OF BUSINESS OR INDUSTRY	
13a. STATE MD.		13b. COUNTY Wicom		13c. CITY OR TOWN Salis.		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS 504 COLLINS ST			
14. FATHER'S NAME FIRST MIDDLE LAST THOMAS CHANEY		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST MILKED SMITH		16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) no		16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) 216-70-6115		17. INFORMANT ADDRESS M. L DRED SMITH 504 COLLINS ST			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 9654 DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last. (b) DUE TO, OR AS A CONSEQUENCE OF (c)										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a).											
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?								20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
21a. EXTERNAL CAUSE WAS UNDERLYING <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH		21b. TIME OF INJURY HOUR:MIN. MONTH DAY YEAR 7:50 P.M. 4 27 80		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2) subject shot by assailant							
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input checked="" type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input checked="" type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, OR IN VEHICLE, ETC.) street		21f. LOCATION Collins St. Salisbury, Maryland STATE							
22a. I certify that I took charge of the remains described above, held on Autopsy <input checked="" type="checkbox"/> , Inspection <input type="checkbox"/> , Inquiry <input type="checkbox"/> , and in my opinion death resulted from: Natural causes <input type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input checked="" type="checkbox"/> , Undetermined manner <input type="checkbox"/> .											
ACTUAL SIGNATURE Margarita A. Korell		TITLE (SPECIFY) Assistant		MEDICAL EXAMINER 111 Penn Street				DATE SIGNED 4-28-80			
EXAMINER'S NAME (TYPE OR PRINT) Margarita A. Korell, M.D.		ADDRESS									
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)		23b. DATE 5/2/80		23c. NAME OF CEMETERY OR CREMATORY Greenwood Mem A Salis.		23d. LOCATION (CITY AND TOWN) Salisbury		COUNTY Wicomico		STATE MD	
24. FUNERAL DIRECTOR West-Farber F.H. Salis, M.D.		25. DATE OF DEATH MAY 7 1980		25a. NAME OF REGISTRAR		25b. REGISTRAR'S SIGNATURE Margarita A. Korell					



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled up by the funeral director, page 2 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed in the office of the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal. IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified once.

1. DECEASED NAME (TYPE OR PRINT)				2a. DATE OF DEATH				2b. HOUR			
Mary E. Cropper				APRIL 23, 1980				12 ⁰⁵ AM			
3 SEX		4 RACE		5 DATE OF BIRTH		6 AGE (IN YEARS LAST BIRTHDAY)		7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)		7b. CITIZEN OF WHAT COUNTRY?	
Female		Cauc.		Aug 19 1897		82 YRS.		Md.		USA	
10 CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION		12a. USUAL OCCUPATION		12b. KIND OF BUSINESS OR INDUSTRY		9. BALTIMORE CITY OR COUNTY OF DEATH			
Salisbury		Peninsula General Hospital		Housewife		Home		Wicomico Md.			
13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)				13b. CITY OR TOWN				13c. STREET ADDRESS			
Md. Worcester				Berlin				Rt. 2, Box 581			
14 FATHER'S NAME				15. MOTHER'S MAIDEN NAME				16a. WAS DECEASED EVER IN U.S. ARMED FORCES?			
John - Griffin				Mary - Coffin				No (YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES)			
16b. SOCIAL SECURITY NO				17. INFORMANT				17. ADDRESS			
214-32-7013-04				Sewell D. Cropper				Rt 2, Box 581 Berlin, Md.			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART I. DEATH WAS CAUSED BY:											
IMMEDIATE CAUSE (a) <u>arteriosclerotic heart disease</u>											
DUE TO, OR AS A CONSEQUENCE OF											
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last											
DUE TO, OR AS A CONSEQUENCE OF											
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a)											
<u>congestive heart failure</u>											
19a. DATE OF OPERATION				19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY?		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?	
								YES <input type="checkbox"/> NO <input type="checkbox"/>		YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				21b. TIME OF INJURY				21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)			
				HOUR A.M. MONTH DAY YEAR							
				P.M. 19							
21d. INJURY OCCURRED				21e. PLACE OF INJURY				21f. LOCATION			
WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>				(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)				CITY OR TOWN COUNTY STATE			
22a. I certify that (I) (this hospital) attended the deceased from <u>4/11</u> , 19 <u>80</u> , to <u>4/23</u> , 19 <u>80</u> , that (I) met lost saw the deceased alive on <u>4/22</u> , 19 <u>80</u> , and that in (my) own opinion death occurred on the date and hour and from the causes stated above, (I) we (did) not view the body after death.											
22b. SIGNATURE				DEGREE				22c. DATE SIGNED			
Rodney A. Wenrich				MD				4/23/86			
22d. PHYSICIAN'S NAME (TYPE OR PRINT)				22e. ADDRESS							
RODNEY A. WENRICH				KAY AVE. SALISBURY Md.							
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)				23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION		23e. COUNTY	
Burial				4/26/80		Evergreen Cem.		Berlin		Worcester Md.	
24. FUNERAL DIRECTOR				25a. DATE REC'D. BY REGISTRAR				25b. REGISTRAR'S SIGNATURE			
Anna A. Barbary				APR 28 1980				Rodney A. Wenrich			
NAME				ADDRESS							
				108 Williams St. Berlin, Md.							

24-25-13-2 Jewell D.C. 1/12/13 10:11 AM

BP

DHMH - 16 50M 7/77
(VR A 15 (4))

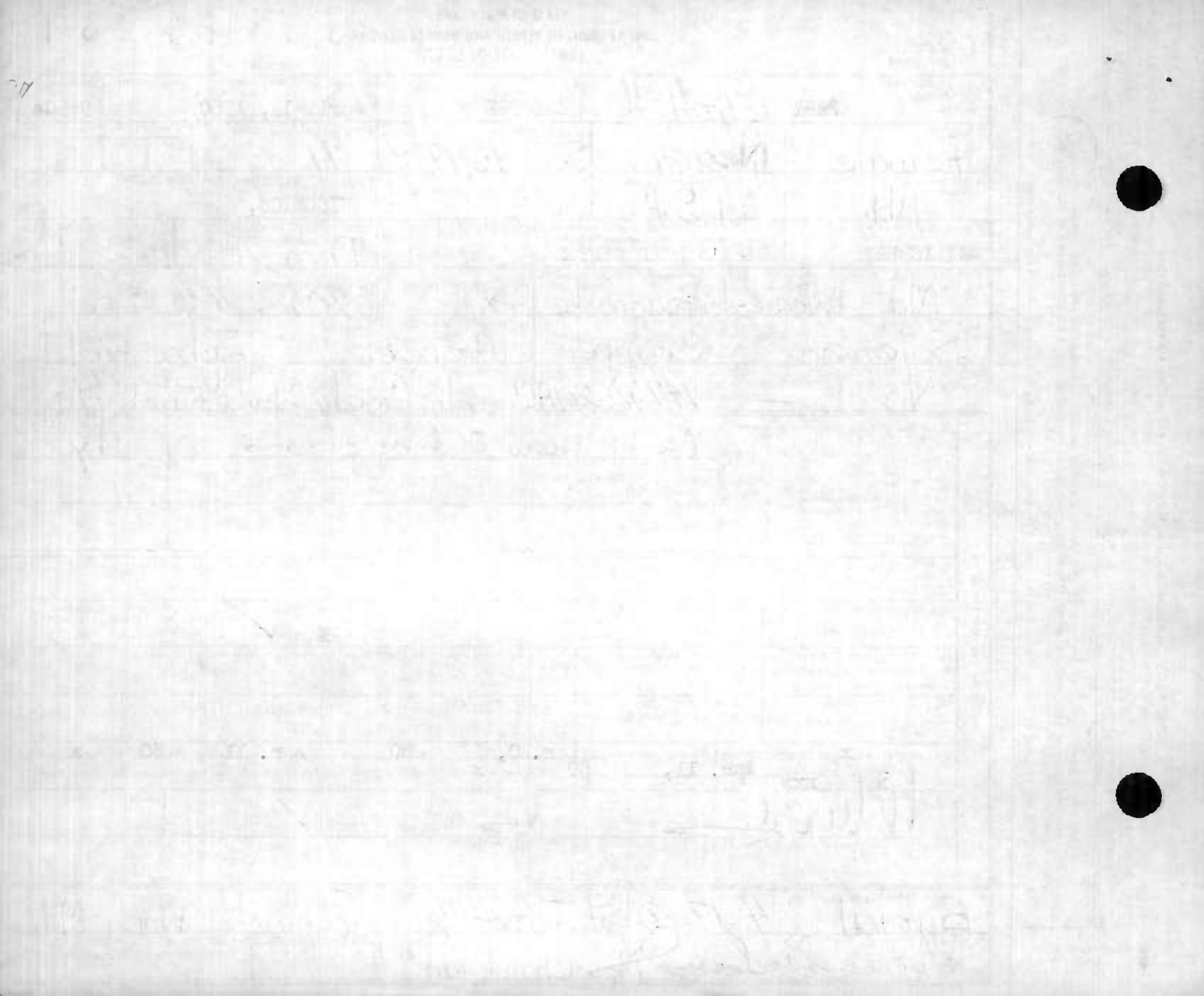
TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial/transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE				8 0 1 1 2 6 1			
1 - FOR STATE REGISTRAR				REG. NO.			
1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST MARY Elizabeth CROPPER				2a. DATE OF DEATH MONTH DAY YEAR April 11, 1980		2b. HOUR 9:50a.m.	
3. SEX Female		4. RACE Negro		5. DATE OF BIRTH MONTH DAY YEAR Sept. 16, 1908		6. AGE (IN YEARS LAST BIRTHDAY) YRS MONTHS DAYS 71	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Md.		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH WICOMICO, MD.	
10. CITY OR TOWN OF DEATH SALISBURY		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) DEER'S HEAD CENTER		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Domestic		12b. KIND OF BUSINESS OR INDUSTRY House Work	
13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13b. STATE 13c. COUNTY 13d. CITY OR TOWN Md. Worcester Pocomoke				13e. STREET ADDRESS 706 - 4th St.		13f. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
14. FATHER'S NAME FIRST MIDDLE LAST Solomon Cropper		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Geneva Schoolfield		16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) 16b. SOCIAL SECURITY NO. No 147-12-261A			
17. INFORMANT ADDRESS Cordelia Gordy New Church, Va. Rt. 1 Bx 27				18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 1539 Ca of slow c liver metastasis DUE TO, OR AS A CONSEQUENCE OF (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____			
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a):							
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)			
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22a. I certify that <input checked="" type="checkbox"/> (this hospital) attended the deceased from Mar. 20, 19 80, to Apr. 11, 19 80, that <input checked="" type="checkbox"/> (we) last saw the deceased alive on Apr. 11, 19 80, and that in <input checked="" type="checkbox"/> (my) (our) opinion death occurred on the date and hour and from the causes stated above <input checked="" type="checkbox"/> (we) (did) (do not) view the body after death.							
22b. SIGNATURE <i>W. H. Hald</i>				DEGREE <i>MD</i> ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input checked="" type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED	
22d. PHYSICIAN'S NAME (TYPE OR PRINT)				22e. ADDRESS			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE 4-19-80		23c. NAME OF CEMETERY OR CREMATORY St. James Cem. Pocomoke		23d. LOCATION CITY OR TOWN COUNTY STATE Wor. Md.	
24. FUNERAL DIRECTOR NAME <i>Barney Delaney</i>				25a. DATE REG'D. BY REGISTRAR APR 22 1980		25b. REGISTRAR'S SIGNATURE <i>Anthony Delaney</i>	



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

MEDICAL CERTIFICATION

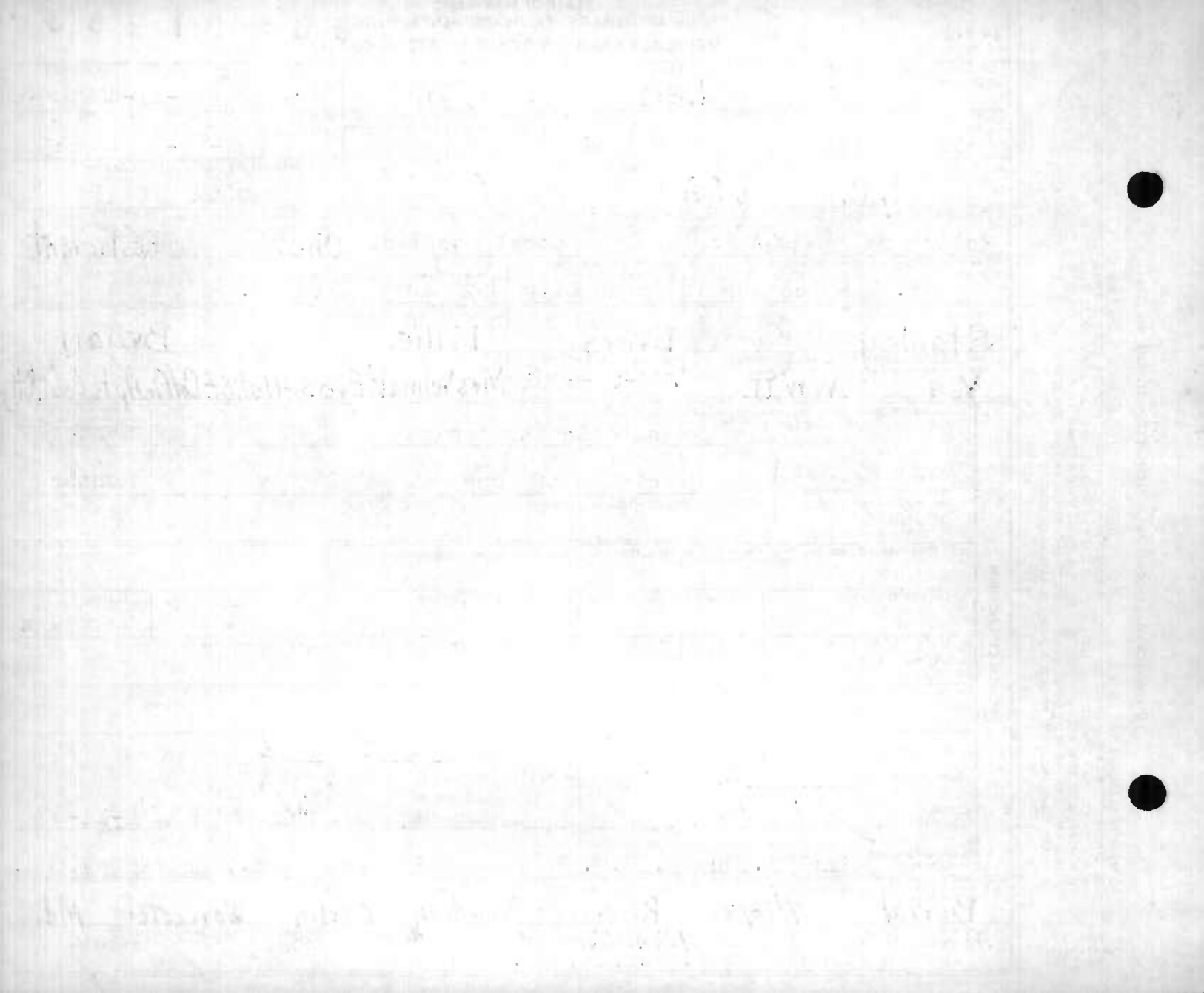
STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE				8 0 1 1 2 6 2	
1- FOR STATE REGISTRAR				REG. NO.	
1 DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST HARRY MORRISON ENNIS			2a. DATE OF DEATH MONTH DAY YEAR APRIL 9 1980		2b. HOUR 8 ³⁵ AM
3 SEX male	4 RACE white	5 DATE OF BIRTH MONTH DAY YEAR Feb. 23, 1921		6 AGE (IN YEARS LAST BIRTHDAY) 59 YRS.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Maryland		7b. CITIZEN OF WHAT COUNTRY? USA		8 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	
10 CITY OR TOWN OF DEATH Salisbury		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Peninsula General Hospital		9 BALTIMORE CITY OR COUNTY OF DEATH Wicomico MD.	
12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Farmer			12b. KIND OF BUSINESS OR INDUSTRY		
13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE Maryland					
13b. COUNTY Worcester		13c. CITY OR TOWN Pocomoke		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
14 FATHER'S NAME FIRST MIDDLE LAST Choley			15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Myra Butler		
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) no		16b. SOCIAL SECURITY NO 218-12-1508		17 INFORMANT ADDRESS Margaret Ennis Dividing Creek Road Pocomoke City, Md.	
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Acute Myocardial Infarction</u> 410- DUE TO, OR AS A CONSEQUENCE OF (b) <u>Atherosclerosis</u> DUE TO, OR AS A CONSEQUENCE OF (c) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost					APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 3 hrs
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a) <u>Chronic obstructive pulmonary disease</u>					
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)	
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE	
22a. I certify that (I) (this hospital) attended the deceased from <u>4.9</u> 19 <u>79</u> , to <u>4.9</u> 19 <u>79</u> , that (we) (we) last saw the deceased alive on <u>4.9</u> 19 <u>79</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.					
22b. SIGNATURE <u>Roger C. Merrill</u>				22c. DATE SIGNED 4.9.80	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) ROGER C. MERRILL				22e. ADDRESS RAY AVE SALISBURY MD 21801	
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE 4/12/80		23c. NAME OF CEMETERY OR CREMATORY Rehobeth Baptist Cem. Rehobeth Som. Md.	
23d. LOCATION CITY OR TOWN Salisbury		23e. COUNTY Som.		23f. STATE Md.	
24. FUNERAL DIRECTOR NAME Scotts Melson				25a. DATE REC'D. BY REGISTRAR APR 14 1980	
25b. REGISTRAR'S SIGNATURE <u>Scotts Melson</u>				25c. ADDRESS Pocomoke City, Md.	

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PA 3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

BP
DHMM - 17
(VR A15 ME (5))
30M 7/73

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

1- STATE REGISTRAR		REG. NO.	
1. DECEASED NAME (TYPE OR PRINT)		2a. DATE OF DEATH KNOWN <input checked="" type="checkbox"/> ESTIMATED <input type="checkbox"/>	
FOSTER Lee EVERS, Sr.		4-11-80 6:30P	
3. SEX	4. RACE	5. DATE OF BIRTH	6. AGE (IN YEARS)
Male	White	7 13 20	59 YRS.
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)		7b. CITIZEN OF WHAT COUNTRY?	
N.C.		USA	
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION	
Salisbury		DOA Peninsula General Hospital	
12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		12b. KIND OF BUSINESS OR INDUSTRY	
Chef		Restaurant	
13a. STATE		13b. COUNTY	
Md.		Worcester	
13c. CITY OR TOWN		13d. INSIDE CITY LIMITS?	
Ocean City		YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
13e. STREET ADDRESS		13f. STREET ADDRESS	
		41st St.	
14. FATHER'S NAME		15. MOTHER'S MAIDEN NAME	
Stanley Evers		Lillie Bryan	
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN)		16b. SOCIAL SECURITY NO.	
Yes		220-07-5951	
17. INFORMANT		ADDRESS	
Mrs Velma V. Evers		41st St. Coffin Apts. Ocean City Md.	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART I DEATH WAS CAUSED BY:			
IMMEDIATE CAUSE (a) Metastatic Carcinoma		months	
DUE TO, OR AS A CONSEQUENCE OF			
(b) Carcinoma of Lung		months	
DUE TO, OR AS A CONSEQUENCE OF			
(c)			
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a).			
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?	
20. AUTOPSY?		YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR	
		P.M. 19	
21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)			
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)	
21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22a. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> .			
ACTUAL SIGNATURE		TITLE (SPECIFY)	
		M.D. Deputy MEDICAL EXAMINER	
EXAMINER'S NAME (TYPE OR PRINT)		DATE SIGNED	
Earl L. Royer, M.D.		4-14-80	
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)		23b. DATE	
Burial		4/16/80	
23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION CITY OR TOWN COUNTY STATE	
Riverside Cemetery		Berlin Worcester Md.	
24. FUNERAL DIRECTOR		25a. DATE RECEIVED BY REGISTRAR	
Anna A. Burtage		APR 17 1980	
ADDRESS 108 Williams St. Burtage Funeral Home, Berlin, Md.		25b. REGISTRAR'S SIGNATURE	



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours at the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

FOR STATE REGISTRAR		STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE		8 0 1 1 2 6 4	
1. DECEASED NAME (TYPE OR PRINT)		2a. DATE OF DEATH		2b. HOUR	
Beulah Belle Fields		APRIL 1, 1980		4:50 AM	
3. SEX	4. RACE	5. DATE OF BIRTH	6. AGE (IN YEARS LAST BIRTHDAY)	7. BALTIMORE CITY OR COUNTY OF DEATH	
Female	White	April 30, 1889	90 YRS	Wicomico MD.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)	7b. CITIZEN OF WHAT COUNTRY?	8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	9. BALTIMORE CITY OR COUNTY OF DEATH		
Maryland	USA		Wicomico		
10. CITY OR TOWN OF DEATH	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)	12. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)	12b. KIND OF BUSINESS OR INDUSTRY		
Salisbury	Peninsula General Hospital	Housewife	none		
13a. STATE		13b. COUNTY	13c. CITY OR TOWN	13d. INSIDE CITY LIMITS?	13e. STREET ADDRESS
Maryland	Wicomico	Eden	YES <input type="checkbox"/> NO <input type="checkbox"/>	Rt. 1, Walnut Tree Road	
14. FATHER'S NAME		15. MOTHER'S MAIDEN NAME		16. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)	
Albert Smith		Mary Hilghman		NO	
16b. SOCIAL SECURITY NO.		17. INFORMANT (son)		17b. ADDRESS	
218-20-2662		A Mr. Garland G. Fields		Rt. 1, Meadow Bridge, Salisbury, MD.	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)					APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART 1. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Massive Myocardial Infarction					
410- DUE TO, OR AS A CONSEQUENCE OF (b)					
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last DUE TO, OR AS A CONSEQUENCE OF (c)					
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) Recurrent Congestive Heart Failure Secondary to Aortic Stenosis					
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20. AUTOPSY?	
				YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)	
		HOUR A.M. MONTH DAY YEAR			
		P.M. 19			
21d. INJURY OCCURRED		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION	
WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>				CITY OR TOWN COUNTY STATE	
22. I certify that (I) (this hospital) attended the deceased from 3/26, 1980, to 4/1, 1980, that (I) (we) lost saw the deceased alive on 4/1, 1980, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.					
22b. SIGNATURE		DEGREE		22c. DATE SIGNED	
Benito S. Chan		MD		4/1/80	
22d. PHYSICIAN'S NAME (TYPE OR PRINT)		22e. ADDRESS			
BENITO S. CHAN		544-D Riverside Drive Salisbury			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)		23b. DATE	23c. NAME OF CEMETERY OR CREMATORY	23d. LOCATION	
Burial		4/4/80	Siloam Cemetery	Siloam, Wic., Maryland	
24. FUNERAL DIRECTOR		25a. DATE REC'D. BY REGISTRAR		25b. REGISTRAR'S SIGNATURE	
HOLLOWAY FUNERAL HOME, Salisbury, Md.		APR 3 1980		[Signature]	

Field

1700000

Peninsula Central Hospital

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. (See 4 may be retained by the hospital or attending physician.)

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, cause 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours of death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE										8 0 1 1 2 6 5	
1- FOR STATE REGISTRAR										CERTIFICATE OF DEATH	
REG. NO.											
1 DECEASED NAME (TYPE OR PRINT)			FIRST MIDDLE LAST			2a DATE OF DEATH MONTH DAY YEAR			2b HOUR		
HATTIE MAE FINNEY						APRIL 29 1980			20. M		
3 SEX		4 RACE		5 DATE OF BIRTH MONTH DAY YEAR		6 AGE (IN YEARS LAST BIRTHDAY)			IF UNDER 1 YEAR MONTHS DAYS		IF UNDER 74 HRS HOURS MIN.
F		N		18 6 14		65 YRS.					
7a BIRTHPLACE (STATE OR FOREIGN COUNTRY)			7b CITIZEN OF WHAT COUNTRY?			8 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>			9 BALTIMORE CITY OR COUNTY OF DEATH		
91 ZEBBON			USA						Wicomico MD.		
10 CITY OR TOWN OF DEATH			11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)						12a USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		12b. KIND OF BUSINESS OR INDUSTRY
80 Salisbury			Peninsula General Hospital						DOMESTIC		HOUSEWIFE
USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)											
13a STATE		13b COUNTY		13c CITY OR TOWN		13d INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e STREET ADDRESS			
35 Md.		Wicomico		FRUITLAND				309 ANDERSON ST.			
14 FATHER'S NAME FIRST MIDDLE LAST				15 MOTHER'S MAIDEN NAME FIRST MIDDLE LAST							
220 JAMES HORTON				JOELLA MONTAGUE							
16a WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)				16b SOCIAL SECURITY NO.		17 INFORMANT ADDRESS					
				138-20-4105		JOHN S. FINNEY (ADD. SAME AS ABOVE)					
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Staphylococcal pneumonia & septicemia</u>										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
4834 DUE TO, OR AS A CONSEQUENCE OF (b)											
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last DUE TO, OR AS A CONSEQUENCE OF (c)											
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) <u>Polymyositis; Acute & Chronic Renal Failure due to collagen vascular related findings</u>											
19a DATE OF OPERATION			19b CONDITION FOR WHICH OPERATION WAS PERFORMED				20a AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
21a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19			21c HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)					
21d INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK			21e PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)			21f LOCATION STREET CITY OR TOWN COUNTY STATE					
22a I certify that (I) (this hospital) attended the deceased from <u>3-8</u> , 19 <u>80</u> , to <u>4-29</u> , 19 <u>80</u> , that (I) (we) last saw the deceased alive on <u>4-29-80</u> , 19 <u>80</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.											
22b SIGNATURE <u>James L. Clifford M.D.</u> ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>						22c DATE SIGNED <u>4-29-80</u>					
22d PHYSICIAN'S NAME (TYPE OR PRINT) <u>JAMES L. CLIFFORD M.D.</u>						22e ADDRESS <u>MEDICAL CENTER SALISBURY MD</u>					
23a BURIAL, CREMATION, REMOVAL (TYPE OR PRINT) <u>BURIAL</u>			23b DATE <u>5-3-80</u>		23c NAME OF CEMETERY OR CREMATORY <u>EBENEZER UM.</u>			23d LOCATION CITY OR TOWN COUNTY STATE <u>MT Wesley Wore. Md.</u>			
24 FUNERAL DIRECTOR NAME <u>JOLLEY MEMORIAL CHAPEL</u>			ADDRESS <u>SALISBURY, MD</u>			25a DATE REC'D. BY REGISTRAR <u>MAY 5 1980</u>		25b REGISTRAR'S SIGNATURE <u>[Signature]</u>			

U.S. DEPARTMENT OF AGRICULTURE
BUREAU OF PLANT INDUSTRY
WASHINGTON, D.C.

REPORT OF THE
COMMISSIONER OF PLANT INDUSTRY
FOR THE YEAR 1902

PLANT INDUSTRY
BUREAU OF PLANT INDUSTRY
WASHINGTON, D.C.
1903

PLANT INDUSTRY
BUREAU OF PLANT INDUSTRY
WASHINGTON, D.C.
1903

FOR STATE
HEALTH DEPT.

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

1. DECEASED-NAME (Type or Print) HERBERT LEE GLADDEN			First Middle Last			2a. DATE KNOWN OF ESTI- DEATH MATED <input type="checkbox"/> Month Day Year <input type="checkbox"/> APRIL 3, 1980			2b. HOUR 6:48 PM				
3. SEX MALE		4. RACE WHITE		5. DATE OF BIRTH 3/16/27		6. AGE (In years last birthday) 53 YRS.		IF UNDER 1 YEAR MONTHS DAYS		IF UNDER 24 HRS HOURS MIN			
7a. BIRTHPLACE (State or foreign country) MARYLAND				7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH WICOMICO CO.			2c. DATE PRONOUNCED DEAD Month Day Year APRIL 3, 1980		
10. CITY OR TOWN OF DEATH SALISBURY				11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) AT HOME				12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) NONE			12b. KIND OF BUSINESS OR INDUSTRY		
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE MD.				13b. CITY OR TOWN WICOMICO CO. SALISBURY				13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET AND NUMBER WALSTON SWITCH RD.			
14. FATHER'S NAME MARVIN GLADDON				15. MOTHER'S MAIDEN NAME AGNES P. COX.									
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) YES				16b. SOCIAL SECURITY NO. WAR II 578-34-4915		17. INFORMANT ADDRESS MRS GLADYS FOSTER SALISBURY, MD.							
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) alcoholic liver disease 5713 DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) chronic alcoholism DUE TO, OR AS A CONSEQUENCE OF (c) APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 4 yrs 4 yrs													
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) cerebral atrophy, alcoholic neuropathy													
19a. DATE OF OPERATION				19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?				20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
21a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH <input type="checkbox"/>				21b. TIME OF INJURY Month, Day, Year HOUR A.M. P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)							
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.)		21f. LOCATION Street or R.F.D. No.		City or Town		County		State			
22a. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>													
ACTUAL SIGNATURE John T. Bulkeley				EXAMINER'S NAME (Type) JOHN T. BULKELEY				CHIEF MEDICAL EXAMINER <input type="checkbox"/>		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>	
								22b. DATE SIGNED 4/5/80					
23a. BURIAL, CREMATION, REMOVAL (Specify)				23b. DATE 4/5/1980		23c. NAME OF CEMETERY OR CREMATORY SPRING HILL GRANDER		23d. LOCATION (City or Town) (County) (State) SALISBURY, MD.					
24. FUNERAL DIRECTOR WILSON FUNERAL HOME				ADDRESS SALISBURY, MD.				25a. REC'D BY REGISTRAR DATE APR 7 1980		25b. REGISTERING SIGNATURE <i>Richard A. Bulkeley</i>			

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MD. 21201

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with farm plot. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

FOR MAIL
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ALONG SPANISH CATHEDRAL OF SEVILLE

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, pages should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE										8011267					
1. FOR STATE REGISTRAR					REG. NO.										
1. DECEASED NAME (TYPE OR PRINT)					2a. DATE OF DEATH			MONTH		DAY		YEAR		2b. HOUR	
Ella D. Hall					April 9			1980		11:15		AM			
3. SEX		4. RACE		5. DATE OF BIRTH			6. AGE (IN YEARS LAST BIRTHDAY)			7. IF UNDER 1 YEAR			8. IF UNDER 24 HRS		
female		cuac.		April 15, 1893			86			MONTHS			DAYS		
7b. BIRTHPLACE (STATE OR FOREIGN COUNTRY)		7c. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>			9. BALTIMORE CITY OR COUNTY OF DEATH								
Maryland		U.S.A.					Wicomico MD.								
10. CITY OR TOWN OF DEATH				11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)				12b. KIND OF BUSINESS OR INDUSTRY			
Salisbury				Peninsula General Hospital				housewife							
13a. STATE				13b. COUNTY		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS?		13e. STREET ADDRESS					
Maryland				Worcester		Bishopville		YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		R.D. 1 Box 164					
14. FATHER'S NAME				15. MOTHER'S MAIDEN NAME				16. ADDRESS							
Burton				Davis				Annie Baker							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)				16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES)				17. INFORMANT							
no				215-38-0375				Paul D. Hall, Parsonsburg, Md.							
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)												APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH			
PART 1. DEATH WAS CAUSED BY												2 days			
IMMEDIATE CAUSE (a) Cerebrovascular accident															
4293 DUE TO, OR AS A CONSEQUENCE OF															
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last															
(b) Atherosclerosis.															
DUE TO, OR AS A CONSEQUENCE OF															
(c)															
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)															
19a. DATE OF OPERATION				19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY?		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?					
								YES <input type="checkbox"/> NO <input type="checkbox"/>		YES <input type="checkbox"/> NO <input type="checkbox"/>					
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				21b. TIME OF INJURY				21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)							
				HOUR A.M. MONTH DAY YEAR											
				P.M. 19											
21d. INJURY OCCURRED				21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)				21f. LOCATION							
WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>								STREET CITY OR TOWN COUNTY STATE							
22a. I certify that (I) (this hospital) attended the deceased from 8-29-80 to 4-9-80, that (I) (we) last saw the deceased alive on 4-9-80, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) did (did not) view the body after death.															
22b. SIGNATURE				DEGREE				22c. DATE SIGNED							
Roger Merrill				MD				4-9-80							
22d. PHYSICIAN'S NAME (TYPE OR PRINT)				22e. ADDRESS				22f. MEDICAL PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>							
Roger Merrill MD				307 Kay Ave. Salisbury											
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)				23b. DATE		23c. NAME OF CEMETERY OR CREMATORY				23d. LOCATION					
Burial				4/12/80		Lewis Family Cem.				Whaleysville, Worc. Co., Md.					
24. FUNERAL DIRECTOR				25a. DATE REC'D. BY REGISTRAR				25b. REGISTRAR'S SIGNATURE							
Richard T. Watson Selbyville, Delaware				APR 16 1980				Hickey, M. Brady							

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TO HOSPITAL'S ATTENDING PHYSICIAN. The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR. After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon pages. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal. IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

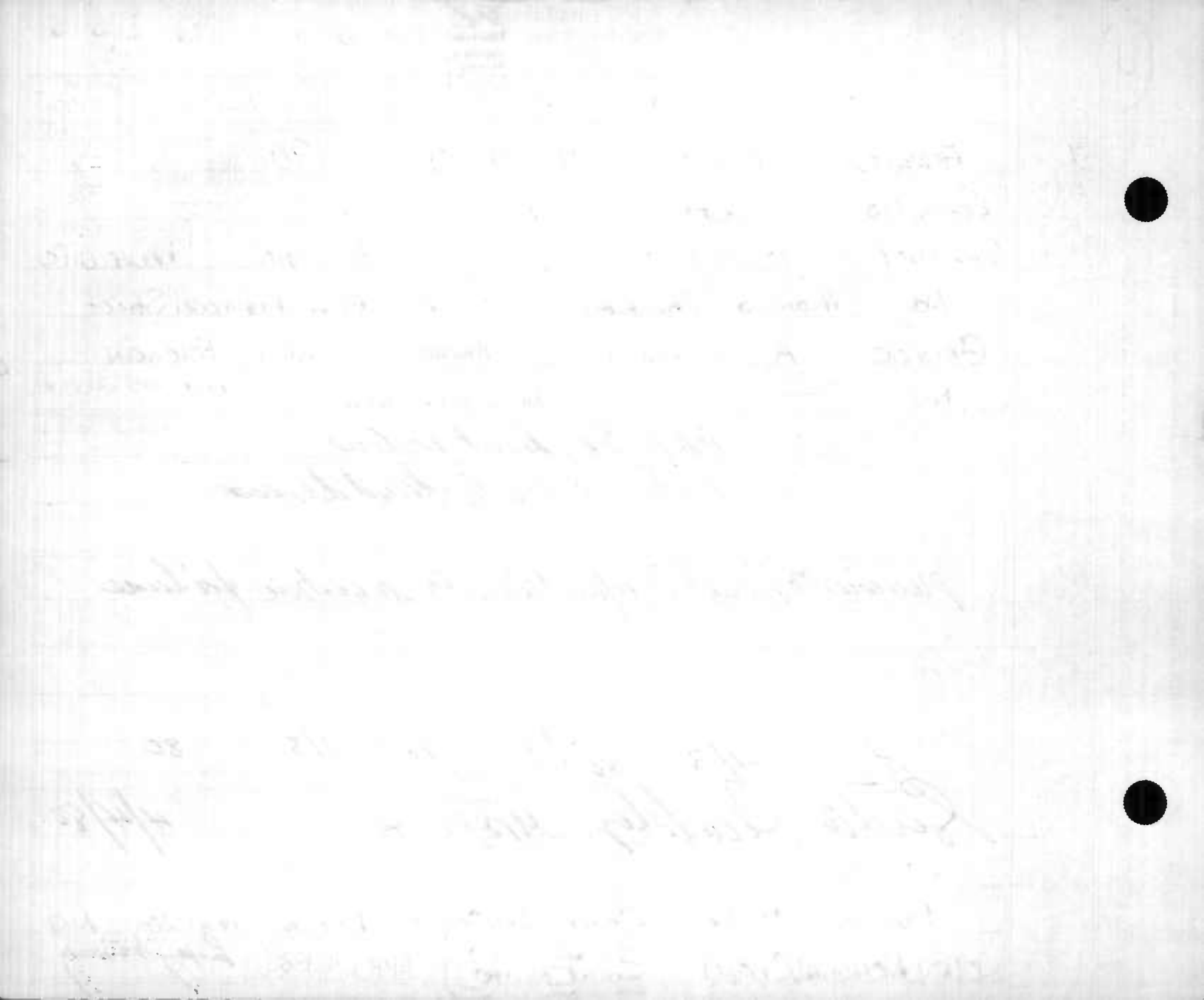
FOR
STATE
REGISTRARSTATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

8 0 1 1 2 6 8

REG. NO.

1. DECEASED NAME (TYPE OR PRINT) HESTER Ellen HARMON			2a. DATE OF DEATH MONTH DAY YEAR 4- 03-1980			2b. HOUR 9:20 P M					
3. SEX Female		4. RACE Black		5. DATE OF BIRTH MONTH DAY YEAR 11 19 89		6. AGE (IN YEARS LAST BIRTHDAY) 90 YRS.		7. IF UNDER 1 YEAR MONTHS DAYS - -		8. IF UNDER 24 HRS HOURS MIN - -	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Berlin, Md		7b. CITIZEN OF WHAT COUNTRY? USA		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH WICOMICO COUNTY MD.					
10. CITY OR TOWN OF DEATH Salisbury		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) SALISBURY NURSING HOME				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) domestic			12b. KIND OF BUSINESS OR INDUSTRY housewife		
USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)											
13a. STATE Md		13b. COUNTY Wicomico		13c. CITY OR TOWN Salisbury		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET ADDRESS Pt. 2, Robinson Street			
14. FATHER'S NAME FIRST MIDDLE LAST George A. Purnell				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Annie M. Foreman							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No				16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES)		17. INFORMANT ADDRESS Mrs. Elmira Smaw same as above.					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Congestive Heart Failure</u> 4140 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last: (b) <u>Coronary Arteriosclerotic Heart Disease</u> (c) <u>Due to, or as a consequence of</u>										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a) <u>Previous Myocardial Infarction with Congestive Failure</u>											
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)					
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)			21f. LOCATION STREET CITY OR TOWN COUNTY STATE					
22. I certify that (I) (this hospital) attended the deceased from <u>3/1</u> 19 <u>78</u> , to <u>4/3</u> 19 <u>80</u> , that (I) (we) lost saw the deceased alive on <u>4/3</u> 19 <u>80</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did not) view the body after death.											
22a. SIGNATURE <u>Earl M. Beardsley</u>				DEGREE MD				22b. ADDRESS U.S. 50-CIVIC AVE., SALISBURY, MD. 21801		22c. DATE SIGNED 4/4/80.	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) DR. EARL M. BEARDSLEY, M.D.				22e. ADDRESS U.S. 50-CIVIC AVE., SALISBURY, MD. 21801							
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) BURIAL			23b. DATE 4-7-80		23c. NAME OF CEMETERY OR CREMATORY CALVARY U.M. Cemetery			23d. LOCATION CITY OR TOWN COUNTY STATE Berlin Worcester Md.			
24. FUNERAL DIRECTOR NAME Jolley Memorial Chapel				ADDRESS Pt. 2 Jersey Rd Salisbury, Md				25a. DATE REC'D. BY REGISTRAR APR 14 1980		25b. REGISTRAR'S SIGNATURE <u>Patricia Kelly</u>	

BP



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE									
1 - STATE REGISTRAR					REG. NO. 8011269				
1 DECEASED NAME (TYPE OR PRINT) Garland Benner Hawkins					2a. DATE OF DEATH MONTH DAY YEAR APRIL 5, 1980			2b. HOUR 11:30 AM	
3. SEX Female		4 RACE White		5 DATE OF BIRTH MONTH DAY YEAR Aug. 1, 1905		6 AGE (IN YEARS LAST BIRTHDAY) 74 YRS.		IF UNDER 1 YEAR MONTHS DAYS HOURS MIN.	
7a BIRTHPLACE (STATE OR FOREIGN COUNTRY) Maryland		7b CITIZEN OF WHAT COUNTRY? USA		8 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9 BALTIMORE CITY OR COUNTY OF DEATH Wicomico MD.			
10 CITY OR TOWN OF DEATH Salisbury		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Peninsula General Hospital				12a USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Housewife		12b. KIND OF BUSINESS OR INDUSTRY	
13a USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13b STATE DEL					13c. CITY OR TOWN New Castle		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
14 FATHER'S NAME FIRST MIDDLE LAST Lester Clark Uhler					15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST May F. Merrifield				
16a WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) NO		16b SOCIAL SECURITY NO.		17 INFORMANT ADDRESS Janice J. McCready Salisbury, MD					
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) 436- CUIZ & CHF DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) DUE TO, OR AS A CONSEQUENCE OF (c)									APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)									
19a DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)					
21d INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f LOCATION STREET CITY OR TOWN COUNTY STATE					
22a I certify that (I) (this hospital) attended the deceased from 4/5 1980 to 4/5 1980, that (I) (we) last saw the deceased alive on 4/5 1980, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.									
22b SIGNATURE W.B. Horner M.D.				DEGREE ATTENDING <input checked="" type="checkbox"/> MEDICAL <input type="checkbox"/> STAFF <input type="checkbox"/> PHYSICIAN DIRECTOR PHYSICIAN				22c DATE SIGNED 4/5/80	
22d PHYSICIAN'S NAME (TYPE OR PRINT) W.B. Horner, M.D.				22e ADDRESS Salisbury, MD					
23a BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b DATE 4/9/80		23c NAME OF CEMETERY OR CREMATORY Gracelawn Mem. Park Wilm.		23d LOCATION CITY OR TOWN COUNTY STATE New Castle DEL			
24 FUNERAL DIRECTOR NAME Alleen J. McCready				ADDRESS 2700 Washington St. Wilm. DE		25a DATE REC'D. BY REGISTRAR APR 17 1980		25b REGISTRAR'S SIGNATURE	

BP

CONFIDENTIAL

10/1/52

RECEIVED

White Aug. 1, 1952

USA

Salisbury, Delaware General Hospital

DLH New Castle Wilmington X #1 Indiana St.

Lester Clark White May

NO Janice J. McGeehan Salisbury, MD

X

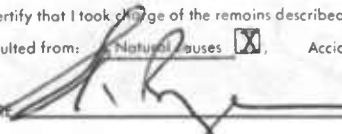
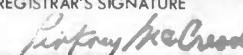
W.E. Horner, M.D. Salisbury, MD

Burial 410180 Lancaster, Pa. New Castle

2700 Washington St.

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL-TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED WITHIN 48 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

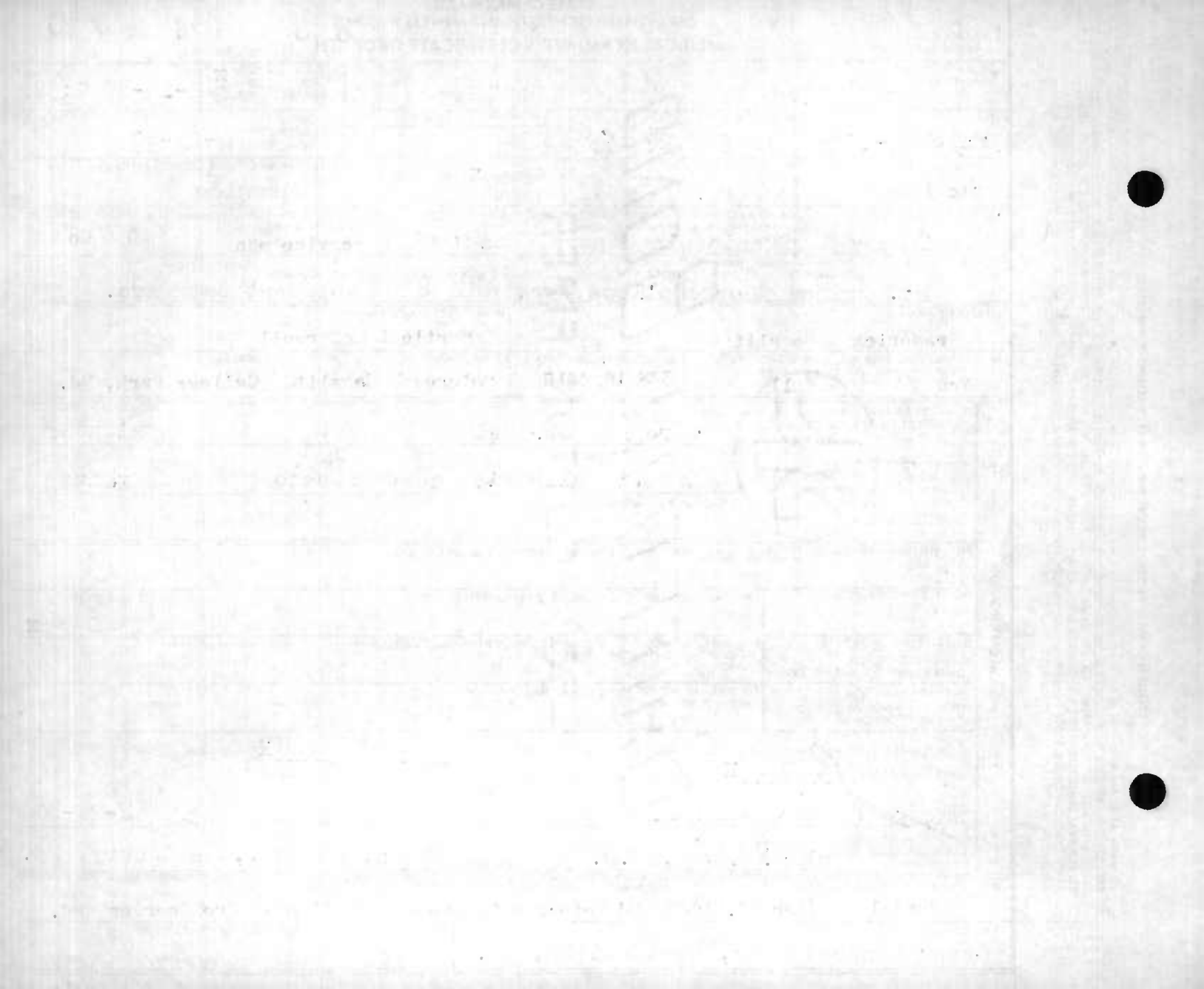
MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE MEDICAL EXAMINER'S CERTIFICATE OF DEATH										REG. NO. 11270	
1. FOR STATE REGISTRAR		2a. DECEASED NAME (TYPE OR PRINT) THEODORE W HEAZLIT						2b. DATE KNOWN OF DEATH <input checked="" type="checkbox"/> MONTH <input type="checkbox"/> DAY <input type="checkbox"/> YEAR 4-23-80		2c. HOUR 9:59P	
3. SEX Male	4. RACE White	5. DATE OF BIRTH MONTH 4 DAY 30 YEAR 24	6. AGE (IN YEARS) LAST BIRTHDAY 55 YRS.	IF UNDER 1 YR. MONTHS <input type="checkbox"/> DAYS <input type="checkbox"/>	IF UNDER 24 HRS. HOURS <input type="checkbox"/> MIN <input type="checkbox"/>	2c. DATE PRONOUNCED DEAD 4-23-80		2d. HOUR 11		2e. MIN <input type="checkbox"/>	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Michigan		7b. CITIZEN OF WHAT COUNTRY? U S A		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Wicomico MD.					
10. CITY OR TOWN OF DEATH Salisbury		11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Peninsula General Hospital				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Service man		12b. KIND OF BUSINESS OR INDUSTRY W G L Co			
13a. USUAL RESIDENCE (IF IN NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE Md. 13b. CITY OR TOWN Prince George College Park				13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS 6901 Dartmouth Ave.					
14. FATHER'S NAME FIRST Frederick W MIDDLE Heazlit LAST Heazlit				15. MOTHER'S MAIDEN NAME FIRST Myrtle L MIDDLE McCarroll LAST McCarroll							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) Yes		16b. SOCIAL SECURITY NO. WW 11		17. INFORMANT Delores M Heazlit				17. ADDRESS College Park, Md.			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Coronary Occlusion 410- Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last. (b) Arteriosclerotic Heart Disease DUE TO, OR AS A CONSEQUENCE OF (c) APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH minutes											
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a).											
19a. DATE OF OPERATION				19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?				20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH				21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19				21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)			
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK				21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)				21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22a. I certify that I took charge of the remains described above, held on Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/> .											
ACTUAL SIGNATURE 				TITLE (SPECIFY) Deputy MEDICAL EXAMINER				DATE SIGNED 4-24-80			
EXAMINER'S NAME (TYPE OR PRINT) Earl L. Royer, M.D.				ADDRESS 409 Camden Ave., Salisbury, Md.							
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial				23b. DATE Apr 28, 1980		23c. NAME OF CEMETERY OR CREMATORY Md Veterans Cemetery		23d. LOCATION CITY OR TOWN COUNTY STATE Cheltenham Pro Georges Md.			
24. FUNERAL DIRECTOR NAME Gasch Funeral Home ADDRESS Hyattsville, Md.						25a. DATE REC'D. BY REGISTRAR APR 23 1980		25b. REGISTRAR'S SIGNATURE 			

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DHMH - 17
(VR A15 ME (5))
30M 7/73

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
IMPORTANT: If Item 21 is marked or Item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH										
1. FOR STATE REGISTRAR					REG. NO.					
1. DECEASED NAME (TYPE OR PRINT) <u>Charles Benjamin Holbrook</u>					2a. DATE OF DEATH MONTH DAY YEAR <u>APRIL 16, 1980</u>			2b. HOUR <u>1:35</u> M		
3. SEX <u>M</u>		4. RACE <u>AA</u>		5. DATE OF BIRTH MONTH DAY YEAR <u>June 10, 1909</u>		6. AGE (IN YEARS LAST BIRTHDAY) <u>78</u> YRS		7. UNDER 1 YEAR MONTHS DAYS		
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <u>md</u>		7b. CITIZEN OF WHAT COUNTRY? <u>USA</u>		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <u>Wicomico</u> MD				
10. CITY OR TOWN OF DEATH <u>Salisbury</u>		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <u>Peninsula General Hospital</u>				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <u>LABOR</u>		12b. KIND OF BUSINESS OR INDUSTRY		
13a. STATE <u>md</u>		13b. COUNTY <u>Wico</u>		13c. CITY OR TOWN <u>Salisbury</u>		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS <u>120 Second Street</u>		
14. FATHER'S NAME FIRST MIDDLE LAST <u>LEVIN HOLBROOK</u>					15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <u>MAGGIE 11</u>					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <u>NO</u>		16b. SOCIAL SECURITY NO. <u>220-09-1100</u>		17. INFORMANT ADDRESS <u>LEONA CROPPER 120 Second St</u>						
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>cerebrovascular bleeding</u> <u>431-</u> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____										
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a): <u>Hypertension</u>										
19a. DATE OF OPERATION <u>4/15</u>				19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR <u>4/15 1980 P.M.</u>		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)				
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>				21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE				
22a. I certify that (I) (the hospital) attended the deceased from <u>4/15</u> , 19 <u>80</u> , to <u>4/16</u> , 19 <u>80</u> , that (I) (we) lost saw the deceased alive on <u>4/15</u> , 19 <u>80</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did not) view the body after death.										
22b. SIGNATURE <u>Rodney A. Wenrich</u>				DEGREE ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>				22c. DATE SIGNED <u>4/16/80</u>		
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <u>RODNEY A. WENRICH</u>				22e. ADDRESS <u>KAY AVE. SALISBURY Md.</u>						
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>Buried</u>		23b. DATE <u>4-22-80</u>		23c. NAME OF CEMETERY OR CREMATORY <u>Quantico Camp</u>		23d. LOCATION CITY OR TOWN COUNTY STATE <u>Quantico Wico md</u>				
24. FUNERAL DIRECTOR NAME <u>West-Farke</u>				ADDRESS <u>Salisbury</u>		25a. DATE REC'D. BY REGISTRAR <u>APR 25 1980</u>		25b. REGISTRAR'S SIGNATURE <u>[Signature]</u>		

St. Mary's General Hospital

St. Mary's

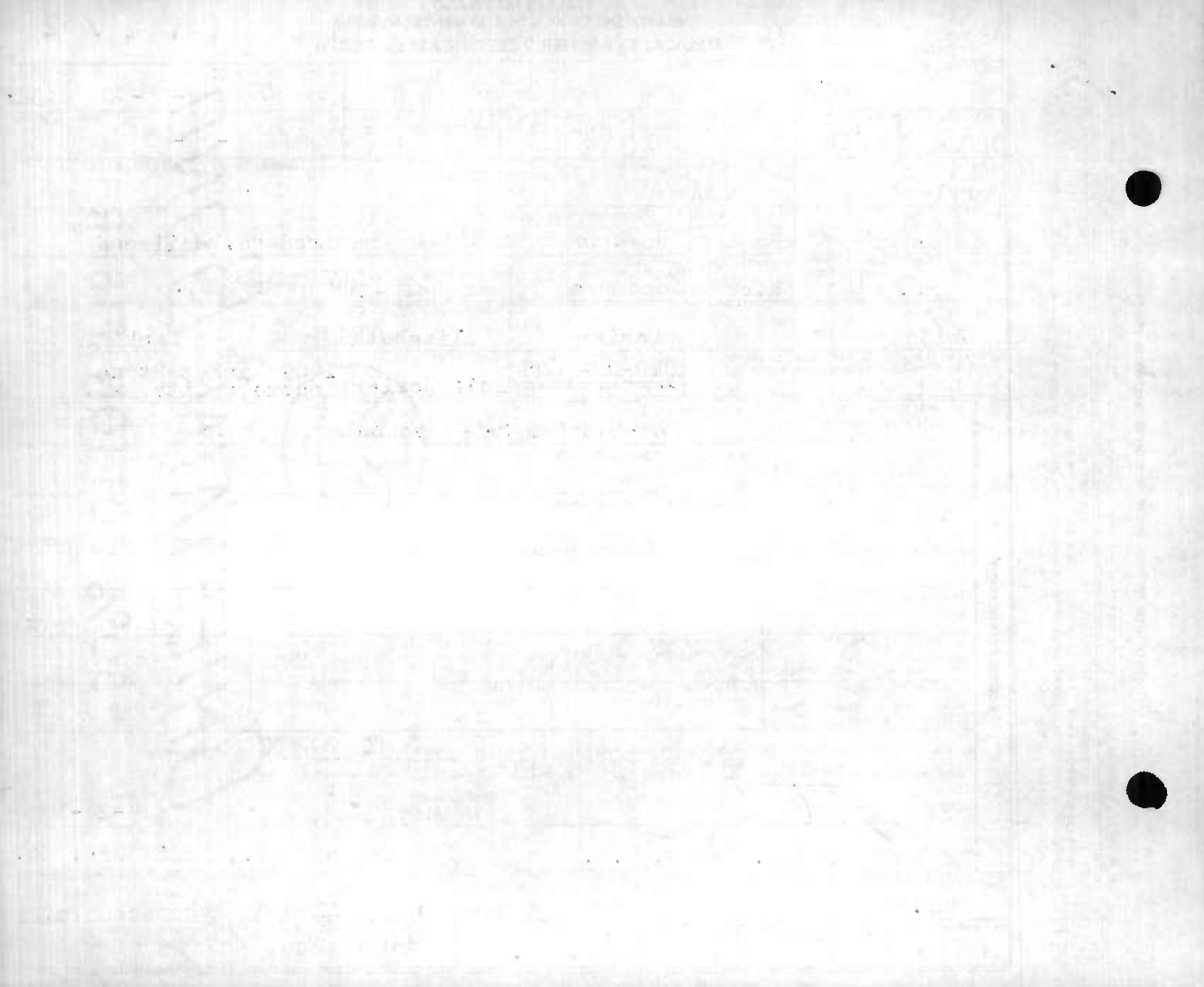
220-22-0001

4-2-74

BP
DHMH - 17
(VR A15 ME (5))
30M 7/73

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, MARK "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PA 3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED WITHIN 24 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

FOR 1- STATE REGISTRAR												DEPARTMENT OF HEALTH AND MENTAL HYGIENE MEDICAL EXAMINER'S CERTIFICATE OF DEATH												REG. NO. 11272			
1. DECEASED NAME (TYPE OR PRINT)						FIRST MIDDLE LAST PURNELL LEE HOSIER						2a. DATE KNOWN OF DEATH ESTIMATED						2b. HOUR 2:32 PM									
3. SEX Male		4. RACE White		5. DATE OF BIRTH MONTH DAY YEAR 7 6 01		6. AGE (IN YEARS) LAST BIRTHDAY YRS. 78		IF UNDER 1 YR. MONTHS DAYS		IF UNDER 24 HRS. HOURS MIN		2c. DATE PRONOUNCED DEAD 4-25-80						2d. HOUR 11 M									
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Maryland				7b. CITIZEN OF WHAT COUNTRY? USA				8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>				9. BALTIMORE CITY OR COUNTY OF DEATH Wicomico MD.															
10. CITY OR TOWN OF DEATH Salisbury				11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Peninsula General Hospital								12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) retired-Pa. Railroad				12b. KIND OF BUSINESS OR INDUSTRY											
13a. STATE Md.				13b. COUNTY Worcester				13c. CITY OR TOWN Pocomoke				13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>				13e. STREET ADDRESS 1409 Market St.											
14. FATHER'S NAME FIRST MIDDLE LAST Elijah Hosier						15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Elizabeth Hopkins						16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) no						16b. SOCIAL SECURITY NO. 520-02-8608									
17. INFORMANT Lois Hosier						17. ADDRESS 1409 Market Street Pocomoke City, Md.																					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Hypertensive Cardiovascular Disease 4029 } DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last. (b) } DUE TO, OR AS A CONSEQUENCE OF (c) }																		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH years									
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a).																											
19a. DATE OF OPERATION						19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?										20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>											
21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH						21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19						21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART I OR PART 2)															
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>						21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)						21f. LOCATION STREET CITY OR TOWN COUNTY STATE															
22a. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/> .																											
ACTUAL SIGNATURE <i>Earl L. Royer</i>						TITLE (SPECIFY) Deputy						DATE SIGNED 4-29-80															
EXAMINER'S NAME (TYPE OR PRINT) Earl L. Royer, M.D.						ADDRESS 409 Camden Ave., Salisbury, Md.																					
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial						23b. DATE 4/27/80						23c. NAME OF CEMETERY OR CREMATORY Groton Cemetery						23d. LOCATION CITY OR TOWN COUNTY STATE Hallwood Accomack Va.									
24. FUNERAL DIRECTOR NAME Nelson Scott's Melson						ADDRESS Watson Funeral Home, Pocomoke, Md.						25a. DATE REC'D. BY REGISTRAR MAY 5 1980						25b. REGISTRAR'S SIGNATURE <i>Harvey McCreedy</i>									



TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE FORMS 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORMS 1, 2, 3, 4, 5, 6, 7, 8, 9, 10, 11, 12, 13, 14, 15, 16, 17, 18, 19, 20, 21, 22, 23, 24, 25, 26, 27, 28, 29, 30, 31, 32, 33, 34, 35, 36, 37, 38, 39, 40, 41, 42, 43, 44, 45, 46, 47, 48, 49, 50, 51, 52, 53, 54, 55, 56, 57, 58, 59, 60, 61, 62, 63, 64, 65, 66, 67, 68, 69, 70, 71, 72, 73, 74, 75, 76, 77, 78, 79, 80, 81, 82, 83, 84, 85, 86, 87, 88, 89, 90, 91, 92, 93, 94, 95, 96, 97, 98, 99, 100. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 301 W. PRESTON ST., BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

BP

DHMH - 17
(VR A15 ME (5))
30M 7/73

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE MEDICAL EXAMINER'S CERTIFICATE OF DEATH														REG. NO.							
1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST CARRIE E. HUTT										2a. DATE KNOWN OF DEATH MONTH DAY YEAR 4-22-80				2b. HOUR 2:50 P.M.							
3. SEX Female		4. RACE AA		5. DATE OF BIRTH MONTH DAY YEAR 5 5 1969		6. AGE (IN YEARS) LAST BIRTHDAY 69 YRS.		IF UNDER 1 YR. MONTHS DAYS		IF UNDER 24 HRS. HOURS MIN.		2c. DATE PRONOUNCED DEAD MONTH DAY YEAR 4-22-80		2d. HOUR 11 P.M.							
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Princess Anne				7b. CITIZEN OF WHAT COUNTRY? USA				8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>				9. BALTIMORE CITY OR COUNTY OF DEATH Wicomico MD.									
10. CITY OR TOWN OF DEATH Salisbury				11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) DOA Peninsula General Hospital								12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Domestic		12b. KIND OF BUSINESS OR INDUSTRY Housewife							
13a. STATE Md.														13b. COUNTY Wicomico		13c. CITY OR TOWN Parsonsburg		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET ADDRESS Rt. 1, Forest Grove Rd.	
14. FATHER'S NAME FIRST MIDDLE LAST Washington Cannon								15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Lula Horsey													
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN)				16b. SOCIAL SECURITY NO. 219-05-3436				17. INFORMANT ADDRESS Louise Terry (add. same as above)													
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Carcinoma of the Esophagus 1509 Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last. (b) DUE TO, OR AS A CONSEQUENCE OF (c) DUE TO, OR AS A CONSEQUENCE OF APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH years																					
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a).																					
19a. DATE OF OPERATION				19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?								20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>									
21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH				21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19				21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)													
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>				21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)				21f. LOCATION STREET		CITY OR TOWN		COUNTY		STATE							
22a. I certify that I took charge of the remains described above, held on Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>																					
ACTUAL SIGNATURE Earl L. Royer, M.D.				TITLE (SPECIFY) Deputy				DATE SIGNED 4-24-80				MEDICAL EXAMINER									
EXAMINER'S NAME (TYPE OR PRINT) Earl L. Royer, M.D.				ADDRESS 409 Camden Ave., Salisbury, Md.																	
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial				23b. DATE 4-26-80		23c. NAME OF CEMETERY OR CREMATORY St. Mary Baptist				23d. LOCATION CITY OR TOWN COUNTY STATE West Post Office - P. Anne Md.											
24. FUNERAL DIRECTOR NAME Jolley Funeral Home, Salisbury, Md.								ADDRESS		25a. DATE REC'D. BY REGISTRAR MAY 2 1980		25b. REGISTRAR'S SIGNATURE Fritzy Helmsky									

61

10

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL-TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED WITHIN 24 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

BP
DHMH - 17
(VR A15 ME (5))
30M 7/73

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO.

1- FOR
STATE
REGISTRAR

1. DECEASED NAME (TYPE OR PRINT)		FIRST		MIDDLE		LAST		2a. DATE KNOWN OF DEATH		XX MONTH DAY YEAR		2b. HOUR	
Johnny		MILTON		Johnson				XX		4 5 19 80		M	
3. SEX	4. RACE	5. DATE OF BIRTH MONTH DAY YEAR		6. AGE (IN YEARS LAST BIRTHDAY)		IF UNDER 1 YR.		IF UNDER 24 HRS.		2c. DATE PRONOUNCED DEAD		2d. HOUR	
Male	Black	9 20 32		47 YRS.						4 5 19 80		7:40P	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH							
EXMORE, Va		USA		WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		Wicomico County, MD.							
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		12b. KIND OF BUSINESS OR INDUSTRY							
Salisbury		Peninsula General Hospital		truck driver		Steel							
13a. STATE		13b. COUNTY		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS?		13e. STREET ADDRESS					
Md		Worcester		BERLIN		YES <input type="checkbox"/> NO <input type="checkbox"/>		P.O. Box 313 Poplar LAWE					
14. FATHER'S NAME		15. MOTHER'S MAIDEN NAME											
MILTON		JOHNSON		MATTIE		ROBINSON							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN)		16b. SOCIAL SECURITY NO.		17. INFORMANT		ADDRESS							
Yes		Korean Conflict		220-26-7772		Romaine Johnson		Same as above					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I DEATH WAS CAUSED BY:		IMMEDIATE CAUSE (a)		Multiple gunshot wounds (rifle)		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH							
9652		DUE TO, OR AS A CONSEQUENCE OF											
Conditions, if any, which gave rise to immediate cause (a) stating the under- lying cause lost.		(b)		DUE TO, OR AS A CONSEQUENCE OF									
		(c)											
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a).													
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?		20. AUTOPSY?									
				YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>									
21a. EXTERNAL CAUSE WAS UNDERLYING <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH		21b. TIME OF INJURY HOUR XX MONTH DAY YEAR		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)									
5 P.M. 4 5 19 80		subject shot											
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input checked="" type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)		21f. LOCATION STREET		CITY OR TOWN		COUNTY		STATE			
on street		Flower St.		Berlin		Worcester		MD					
22a. I certify that I took charge of the remains described above, held on death resulted from: Natural causes <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/>		Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion		Homicide <input checked="" type="checkbox"/> Undetermined manner <input type="checkbox"/>									
ACTUAL SIGNATURE		TITLE (SPECIFY)		MEDICAL EXAMINER		DATE SIGNED		4:6/80					
Thomas D. Smith, M.D.		Deputy Chief											
EXAMINER'S NAME (TYPE OR PRINT)		ADDRESS		111 Penn St. Balto., MD.									
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION CITY OR TOWN		COUNTY		STATE			
BURIAL		4-11-80		Evergreen Cemetery		Berlin		Worcester		Md.			
24. FUNERAL DIRECTOR NAME		ADDRESS		25a. DATE REC'D. BY REGISTRAR		25b. REGISTRAR'S SIGNATURE							
Jolley Memorial Chapel		Rt 2 Salisbury Md		APR 14 1980		History McCreedy							

1914

UNITED STATES DEPARTMENT OF AGRICULTURE
BUREAU OF PLANT INDUSTRY

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the registrar, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 24 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified.

MEDICAL CERTIFICATION

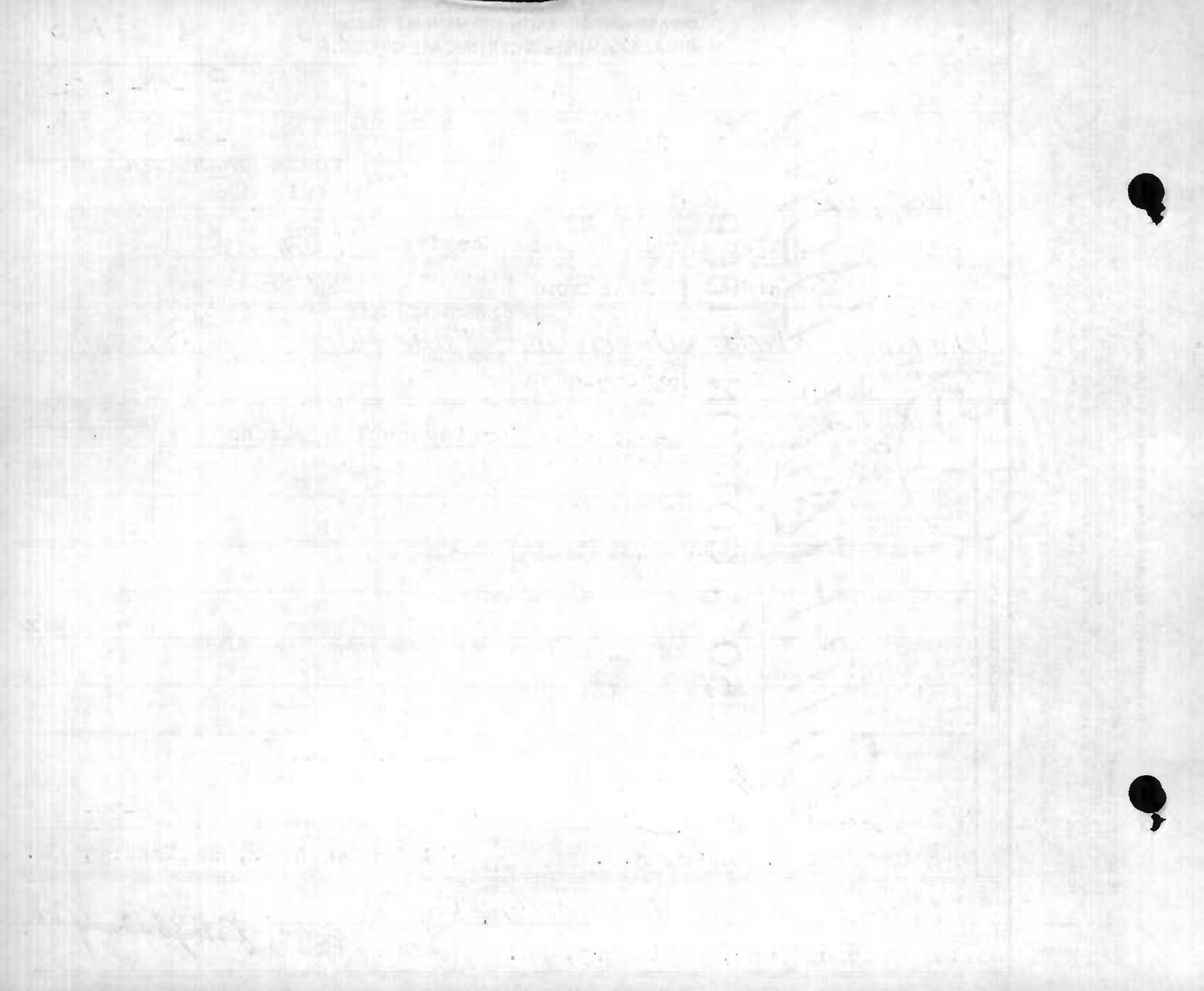
1- FOR STATE REGISTRAR				STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE				8 0 1 1 2 7 5			
1. DECEASED NAME (TYPE OR PRINT)				2a. DATE OF DEATH				2b. HOUR			
Ruth Matilda Johnson				April 15, 1980				6:57 AM			
3. SEX		4. RACE		5. DATE OF BIRTH		6. AGE (IN YEARS LAST BIRTHDAY)		7. UNDER 1 YEAR		7. UNDER 24 HRS	
Female		White		9/15/1909		70 YRS.		MONTHS		DAYS	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH					
Snow Hill, Md.		USA				Wicomico MD.					
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		12b. KIND OF BUSINESS OR INDUSTRY			
Salisbury		Peninsula General Hospital				Registered Nurse-nursing					
13a. STATE				13b. COUNTY		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS?		13e. STREET ADDRESS	
Maryland				Wicomico		Salisbury		YES <input type="checkbox"/> NO <input type="checkbox"/>		307 Ohio Ave.	
14. FATHER'S NAME				15. MOTHER'S MAIDEN NAME							
Charles Lee Johnson				Aline Cordelia Duffy							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)				16b. SOCIAL SECURITY NO		17. INFORMANT (sister) ADDRESS					
NO				217-30-9071		809 Camden Ave. Mrs. Isabelle J. Bennett, Salisbury, Md.					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Septic Shock and CHF</u>								APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <u>2 days</u>			
4149 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost (b) <u>Coronary Artery Disease, Septicemia</u>								53			
(c) <u>Arteriosclerosis</u>								103			
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)											
19a. DATE OF OPERATION				19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY?		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?	
								YES <input type="checkbox"/> NO <input type="checkbox"/>		YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)					
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>				21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE					
22a. I certify that (I) (this hospital) attended the deceased from _____, 19____, to _____, 19____, that (I) (we) lost saw the deceased alive on _____, 19____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.											
22b. SIGNATURE <u>J. L. Raffetto</u> DEGREE <u>MD</u>								ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED 4/23/80	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) J. L. Raffetto								22e. ADDRESS P.G.H.			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)				23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION CITY OR TOWN COUNTY STATE			
Burial				4/18/80		Whatcoat Meth. Cemetery, Snow Hill, Worcester, Maryland					
24. FUNERAL DIRECTOR NAME ADDRESS HOLLOWAY FUNERAL HOME, Salisbury, Maryland								25. DATE REC'D. BY REGISTRAR		25. REGISTRAR'S SIGNATURE [Signature]	
								APR 24 1980			

BP _____

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PA 3. RETAIN PAGE 5 FOR YOUR FILE. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL-TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED WITHIN 10 DAYS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE MEDICAL EXAMINER'S CERTIFICATE OF DEATH										REG. NO. 11276	
1. FOR STATE REGISTRAR										2a. DATE KNOWN OF DEATH	
1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST WILLIAM EDWARD JOHNSON, JR.										2b. DATE KNOWN OF DEATH ESTIMATED 4-20-80 5:43P	
3. SEX Male		4. RACE AA		5. DATE OF BIRTH 2 18 21		6. AGE (IN YEARS) 59 YRS.		IF UNDER 1 YR. MONTHS DAYS		IF UNDER 24 HRS. HOURS MIN	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Mt. Wesley Md				7b. CITIZEN OF WHAT COUNTRY? USA				8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Wicomico MD.	
10. CITY OR TOWN OF DEATH Salisbury				11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Peninsula General Hospital				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Disabled		12b. KIND OF BUSINESS OR INDUSTRY	
USUAL RESIDENCE (IF IN NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)											
13a. STATE Md.		13b. COUNTY Worcester		13c. CITY OR TOWN Stockton		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS Bay Road			
14. FATHER'S NAME FIRST MIDDLE LAST William Edward Johnson Sr.						15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Foster Brown					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) Yes				16b. SOCIAL SECURITY NO. 1 WMT		17. INFORMANT ADDRESS 218-10-0438					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Hypertensive Cardiovascular Disease</u> 4029 DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last. (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH years	
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a).											
19a. DATE OF OPERATION				19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?						20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH				21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)					
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>				21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE					
22a. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/> .											
ACTUAL SIGNATURE <i>Earl L. Royer</i>						TITLE (SPECIFY) Deputy		DATE SIGNED 4-22-80			
EXAMINER'S NAME (TYPE OR PRINT) Earl L. Royer, M.D.						ADDRESS 409 Camden Ave., Salisbury, Md.					
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) BURIAL		23b. DATE 4-27-80		23c. NAME OF CEMETERY OR CREMATORY Mt. Wesley Cemetery				23d. LOCATION CITY OR TOWN COUNTY STATE Salisbury Worcester Md			
24. FUNERAL DIRECTOR NAME Jolley Funeral Home, Salisbury, Md.						25a. DATE REC'D. BY REGISTRAR APR 23 1980		25b. REGISTRAR'S SIGNATURE <i>Patricia...</i>			



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, Page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

#5,6, per call w/ F.H. 4/24/80 kam STATE OF MARYLAND
 1 - STATE REGISTRAR DEPARTMENT OF HEALTH AND MENTAL HYGIENE
 CERTIFICATE OF DEATH

REG. NO. 80 11277

1. DECEASED NAME (TYPE OR PRINT) Stella F. JONES			2a. DATE OF DEATH MONTH DAY YEAR April 21 1980		2b. HOUR 5:30a.m.
3. SEX FEMALE	4. RACE C	5. DATE OF BIRTH July 31, 1891		6. AGE (IN YEARS LAST BIRTHDAY) 88 YRS	IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS HOURS MIN
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) MD.	7b. CITIZEN OF WHAT COUNTRY? U.S.A.	8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	9. BALTIMORE CITY OR COUNTY OF DEATH Wicomico MD.		
10. CITY OR TOWN OF DEATH Salisbury	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Deer's Head Center		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) NONE	12b. KIND OF BUSINESS OR INDUSTRY	
13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE MD 13b. COUNTY SOMERSET 13c. CITY OR TOWN PRINCESS ANNE 13d. INSIDE CITY LIMITS? <input type="checkbox"/> NO <input type="checkbox"/>			13e. STREET ADDRESS R.F.D. 3 BOX. 34		
14. FATHER'S NAME FIRST PETE MIDDLE FONTAINE LAST			15. MOTHER'S MAIDEN NAME FIRST RACHEL MIDDLE FONTANIE LAST		
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)		16b. SOCIAL SECURITY NO.	17. INFORMANT ADDRESS MISS MARY JONES PRINCESS ANNE, MD		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) malnutrition 4292 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) ASCVD, severe DUE TO, OR AS A CONSEQUENCE OF (c) DUE TO, OR AS A CONSEQUENCE OF					APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) senile degeneration with contractures, multiple decubitus ulcers					
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19	21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)		
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)	21f. LOCATION STREET CITY OR TOWN COUNTY STATE		
22a. I certify that (I) (this hospital) attended the deceased from _____, 19_____, to _____, 19_____, that (I) (we) last saw the deceased alive on _____, 19_____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.					
22b. SIGNATURE Nancy W. Tustin, M.D.			DEGREE ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/>		22c. DATE SIGNED 4-21-80
22d. PHYSICIAN'S NAME (TYPE OR PRINT) Nancy W. Tustin, M.D.			22e. ADDRESS Deer's Head Center, Salisbury, Md. 21801		
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) BURIAL	23b. DATE 4/26/80	23c. NAME OF CEMETERY OR CREMATORY POLK ROAD CEM.		23d. LOCATION CITY OR TOWN COUNTY STATE NEAR PRINCESS ANNE, MD.	
24. FUNERAL DIRECTOR NAME LEVIN R. WILSON			ADDRESS PRINCESS ANNE, MD.		25. DATE RECEIVED BY REGISTRAR APR 24 1980
			25b. REGISTRAR'S SIGNATURE <i>[Signature]</i>		



1. FOR
STATE
REGISTRAR

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

1. DECEASED NAME (TYPE OR PRINT) Lola Frances LANG			2a. DATE OF DEATH MONTH DAY YEAR April 2, 1980			2b. HOUR 9:30p				
3. SEX Female		4. RACE White		5. DATE OF BIRTH MONTH DAY YEAR 10-27-1891		6. AGE (IN YEARS LAST BIRTHDAY) 88		7. IF UNDER 1 YEAR MONTHS DAYS HOURS MIN		
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Virginia		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Wicomico MD.				
10. CITY OR TOWN OF DEATH Salisbury		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Deer's Head Center				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Teacher		12b. KIND OF BUSINESS OR INDUSTRY Public Schools		
13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE Va.			13b. COUNTY Accomack		13c. CITY OR TOWN Temperanceville		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS	
14. FATHER'S NAME FIRST MIDDLE LAST James C. Lang			15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Ida D. Warner							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No			16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) 230-42-5119		17. MARITAL ADDRESS Don Shumakov, Temperanceville, Va.					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) congestive heart failure 4292 DUE TO, OR AS A CONSEQUENCE OF (b) ASCVD Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (c) DUE TO, OR AS A CONSEQUENCE OF APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH yrs. yrs.										
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a) CVA, (2) hemiplegia										
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)					
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE					
22a. I certify that (I) (this hospital) attended the deceased from _____, 19_____, to _____, 19_____, that (I) (we) last saw the deceased alive on _____, 19_____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.										
22b. SIGNATURE Nancy M. Tustin, M.D.						DEGREE ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/>		22c. DATE SIGNED 4-2-80		
22d. PHYSICIAN'S NAME (TYPE OR PRINT) Nancy M. Tustin, M.D.					22e. ADDRESS Deer's Head Center, Salisbury, Md. 21801					
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial			23b. DATE 4-5-1980		23c. NAME OF CEMETERY OR CREMATORY Taylor Memorial		23d. LOCATION CITY OR TOWN COUNTY STATE Temperanceville Accomack Va.			
24. FUNERAL DIRECTOR NAME Nancy M. Tustin			ADDRESS Temperanceville, Va.			25a. DATE REC'D. BY REGISTRAR APR 8 1980		25b. REGISTRAR'S SIGNATURE Nancy M. Tustin		

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

BP

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, pages 1 and 2 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.



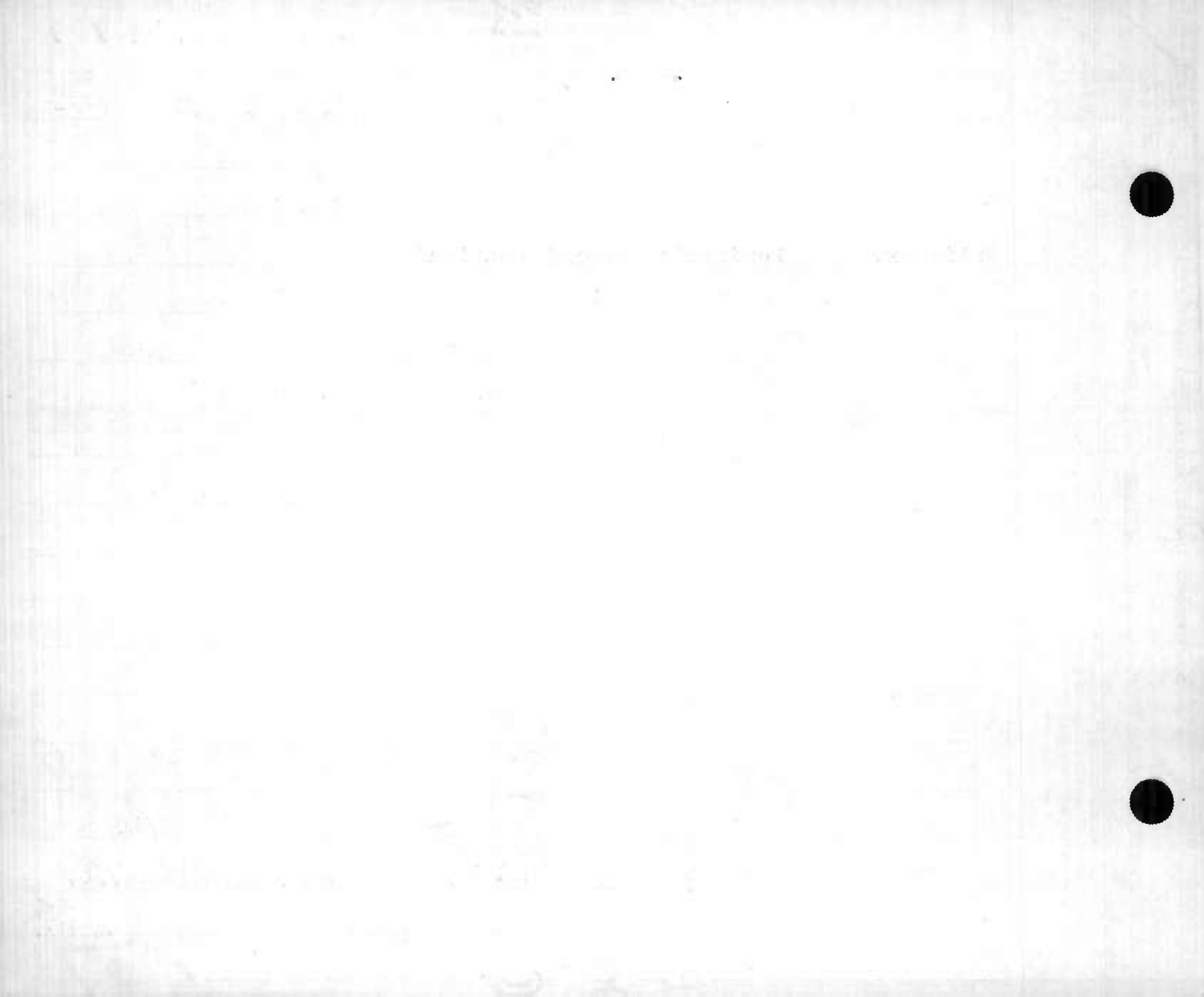
TO HOSPITAL OR ATTENDING PHYSICIAN. The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR. After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbonpapers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

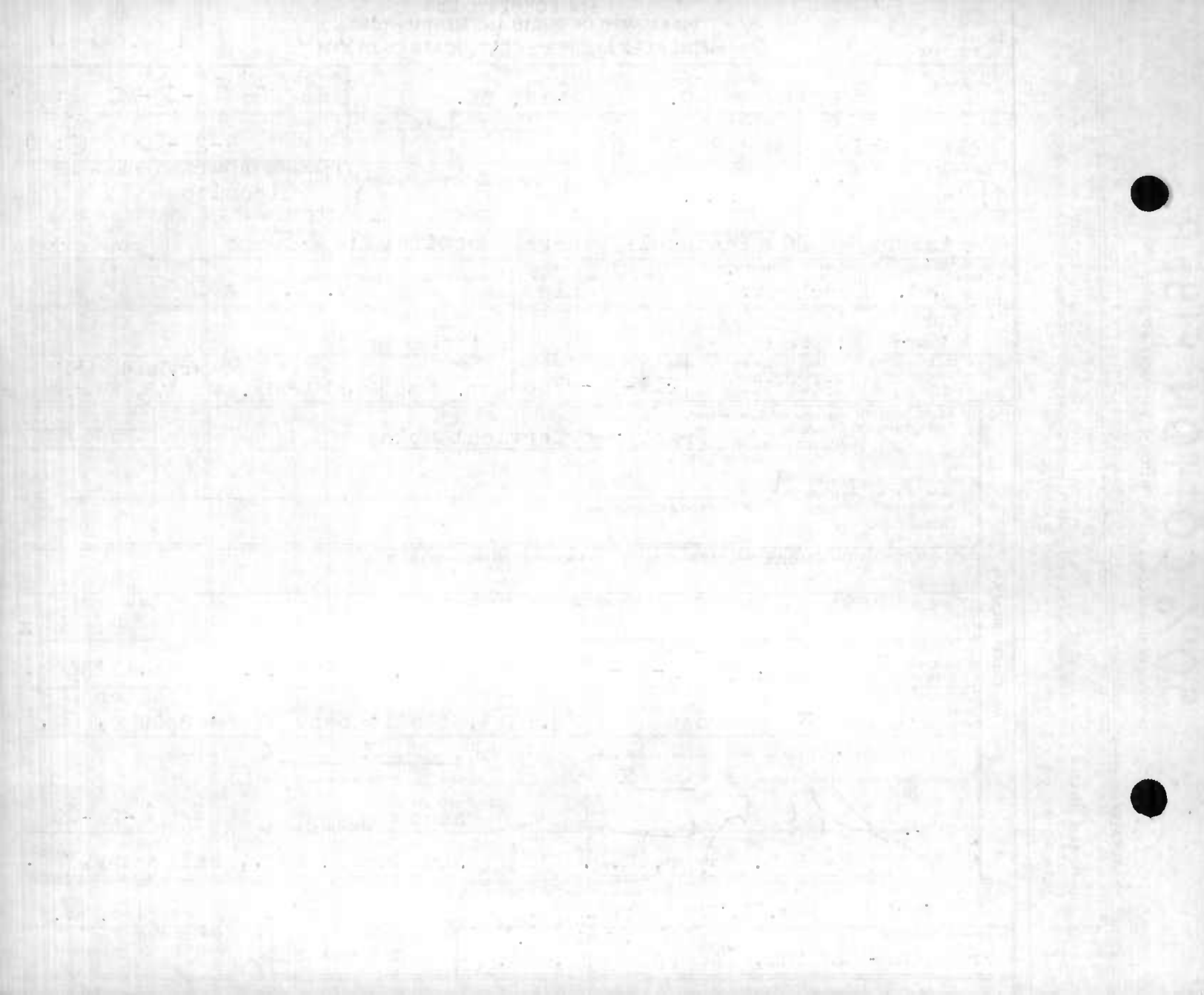
STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE										8 0 1 1 2 7 9	
1- FOR STATE REGISTRAR					CERTIFICATE OF DEATH						
1 DECEASED NAME (TYPE OR PRINT)					2a DATE OF DEATH				2b HOUR		
Edna Mae Leonard					APRIL 8, 1980				12 30 P M		
3 SEX		4 RACE		5 DATE OF BIRTH		6 AGE (IN YEARS LAST BIRTHDAY)		7a IF UNDER 1 YEAR		7b IF UNDER 24 HRS	
Female		White		July 1, 1904		75 YRS.		MONTHS DAYS		HOURS MIN.	
7a BIRTHPLACE (STATE OR FOREIGN COUNTRY)		7b CITIZEN OF WHAT COUNTRY?		8 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9 BALTIMORE CITY OR COUNTY OF DEATH					
Maryland		USA				Wicomico MD.					
10 CITY OR TOWN OF DEATH		11 NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)						12a USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		12b KIND OF BUSINESS OR INDUSTRY	
Salisbury		Peninsula General Hospital						House work		none	
13a STATE		13b COUNTY		13c CITY OR TOWN		13d INSIDE CITY LIMITS?		13e STREET ADDRESS			
Maryland		Worcester		Snow Hill		YES <input type="checkbox"/> NO <input type="checkbox"/>		101 Belt Street			
14 FATHER'S NAME				15 MOTHER'S MAIDEN NAME							
Goldsboro				Parsons				Emma Downes			
16a WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)				16b SOCIAL SECURITY NO.		17 INFORMANT (daughter)		ADDRESS			
No				218-48-6961		Mrs. Mildred L. Davis		Rt. 3, Salisbury, MD.			
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY:										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
IMMEDIATE CAUSE (a) <u>Ventricular Fibrillation</u>											
4/48											
DUE TO, OR AS A CONSEQUENCE OF, (b) <u>old inferior & antroscapital myocardial infarction</u>											
DUE TO, OR AS A CONSEQUENCE OF, (c) <u>Advanced coronary artery disease</u>											
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a)											
<u>Diabetic mellitus & Hypothyroidism</u>											
19a DATE OF OPERATION		19b CONDITION FOR WHICH OPERATION WAS PERFORMED				20a AUTOPSY?		20b IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?			
						YES <input type="checkbox"/> NO <input type="checkbox"/>		YES <input type="checkbox"/> NO <input type="checkbox"/>			
21a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b TIME OF INJURY		21c HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)							
		HOUR A.M. MONTH DAY YEAR									
		P.M. 19									
21d INJURY OCCURRED		21e PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f LOCATION		CITY OR TOWN		COUNTY		STATE	
WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>											
22a I certify that (I) (this hospital) attended the deceased from <u>Jan</u> 19 <u>74</u> to <u>April 8th</u> 19 <u>80</u> , that (I) (we) lost saw the deceased alive on <u>April 8th</u> 19 <u>80</u> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.											
22b SIGNATURE		DEGREE				22c DATE SIGNED					
<u>Joseph Z. Badros</u>		M.D. ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>				4/10/80					
22d PHYSICIAN'S NAME (TYPE OR PRINT)				22e ADDRESS							
Joseph Z. Badros, M.D.				P.O. Box 162, Salisbury, Md. 21801							
23a BURIAL, CREMATION, REMOVAL (SPECIFY)		23b DATE		23c NAME OF CEMETERY OR CREMATORY		23d LOCATION		CITY OR TOWN		COUNTY STATE	
Burial		4/10/80		Parsonsburg Cemetery		Salisbury, Wic.		Md.			
24 FUNERAL DIRECTOR				25a DIED BY REGISTRATION				25b REGISTRAR'S SIGNATURE			
NAME ADDRESS HOLLOWAY FUNERAL HOME, Salisbury, Md.				APR 11 1980				<u>John Brady</u>			

BP _____



TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR OR PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL-TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED, WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE MEDICAL EXAMINER'S CERTIFICATE OF DEATH										REG. NO. 11280	
1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST JOSEPH C. LEWIS, SR.										20. DATE KNOWN OF DEATH ESTIMATED MONTH DAY YEAR 4-23-80 2:40 PM	
3. SEX Male	4. RACE White	5. DATE OF BIRTH MONTH DAY YEAR 4 9 35	6. AGE (IN YEARS) (LAST BIRTHDAY) MONTHS DAYS HOURS MIN. 45 YRS.	7. IF UNDER 1 YR. MONTHS DAYS	8. IF UNDER 24 HRS. HOURS MIN.	21. DATE PRONOUNCED DEAD MONTH DAY YEAR 4-23-80 19 3:20 PM		22. BALTIMORE CITY OR COUNTY OF DEATH Wicomico MD.			
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Livingston Manor, N.Y.		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Wicomico MD.					
10. CITY OR TOWN OF DEATH Salisbury		11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) DOA Peninsula General Hospital				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Dispatcher		12b. KIND OF BUSINESS OR INDUSTRY Acme Markets			
13. USUAL RESIDENCE (IF IN NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE 13b. COUNTY 13c. CITY OR TOWN Md. Dorchester Rhodesdale										13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>	
14. FATHER'S NAME FIRST MIDDLE LAST Joseph R. Lewis										15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Marion Scott	
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) (IF YES, GIVE WAR OR DATES) Yes 1954-1958			16b. SOCIAL SECURITY NO. 219-34-2756			17. INFORMANT ADDRESS Mrs. June Nagel Lewis, Box 145, Rhodesdale Maryland 21659					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Fractured Cervical Spine</u> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last. (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH sudden	
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a).											
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?						20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
21a. EXTERNAL CAUSE WAS UNDERLYING <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH			21b. TIME OF INJURY HOUR MONTH DAY YEAR 2:40 P.M. 4-23-80		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2) Driver of auto involved in collision.						
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input checked="" type="checkbox"/> AT WORK			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.) road		21f. LOCATION STREET CITY OR TOWN COUNTY STATE Rt. 313, 1 mile east of Sharptown, Md. Wicomico						
22a. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and in my opinion death resulted from: Natural causes <input type="checkbox"/> , Accident <input checked="" type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/> .											
ACTUAL SIGNATURE <i>Earl L. Royer</i>			TITLE (SPECIFY) Deputy			DATE SIGNED 4-24-80					
EXAMINER'S NAME (TYPE OR PRINT) Earl L. Royer, M.D.			ADDRESS 409 Camden Ave., Salisbury, Md.								
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE Apr. 28, 1980		23c. NAME OF CEMETERY OR CREMATORY Hillcrest Cemetery			23d. LOCATION CITY OR TOWN COUNTY STATE Federalsburg, Caroline, Md.				
24. FUNERAL DIRECTOR NAME Rampton-Hawkins, Address 216 N. Main St. Federalburg, Md.				25a. DATE REC'D. BY REGISTRAR APR 28 1980		25b. REGISTRAR'S SIGNATURE <i>Walter McCreedy</i>					



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If Item 21 is marked or Item 18 shows any injury, or other traumatic event, the medical examiner must be notified.

MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH									
1. FOR STATE REGISTRAR		8 0 1 1 2 8 1		REG. NO.					
1. DECEASED NAME (TYPE OR PRINT) WILTON HOLLAND MARSHALL				2a. DATE OF DEATH MONTH DAY YEAR APRIL 19 1980		2b. HOUR 11 P.M.			
3. SEX Male		4. RACE Negro		5. DATE OF BIRTH MONTH DAY YEAR 9 8 24		6. AGE (IN YEARS LAST BIRTHDAY) 55 YRS.		7. UNDER 1 YEAR MONTHS DAYS	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Stockton, Md.		7b. CITIZEN OF WHAT COUNTRY? USA		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Wicomico MD			
10. CITY OR TOWN OF DEATH Salisbury		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Peninsula General Hospital				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Retired truck driver		12b. KIND OF BUSINESS OR INDUSTRY Cannery Co.	
13a. STATE Ohio		13b. COUNTY Columbus		13c. CITY OR TOWN Columbus		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS 1124 BERKLEY ROAD	
14. FATHER'S NAME FIRST MIDDLE LAST James Marshall				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST NANCY Foeman					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) Yes		(IF YES, GIVE WAR OR DATES) WWII		16b. SOCIAL SECURITY NO		17. INFORMANT ADDRESS Ms. Sabra Marshall same as above			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Cardiopulmonary arrest								APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
2051 } DUE TO, OR AS A CONSEQUENCE OF Paroxysmal Chronic Myeloid Leukemia									
DUE TO, OR AS A CONSEQUENCE OF (b) Chronic Myeloid Leukemia									
DUE TO, OR AS A CONSEQUENCE OF (c)									
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)									
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)					
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE					
22a. I certify that (I) (this hospital) attended the deceased from April 8 , 19 80 , to April 19 , 19 80 , that (I) (we) last saw the deceased alive on April 19 , 19 80 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.									
22b. SIGNATURE S. A. Abrams MD				DEGREE		ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED 4/19/80	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) S. ALBERT ABRAMS				22e. ADDRESS PENINSULA GENERAL HOSPITAL SALISBURY MD 21801					
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) BURIAL		23b. DATE 4-24-80		23c. NAME OF CEMETERY OR CREMATORY Foeman Cemetery		23d. LOCATION CITY OR TOWN COUNTY STATE Stockton			
24. FUNERAL DIRECTOR NAME Johny Memorial Chapel ADDRESS Jersey Rd Salisbury, Md				25a. DATE REC'D BY REGISTRAR APR 23 1980		25b. SIGNATURE [Signature]			

Salisbury Central General Hospital

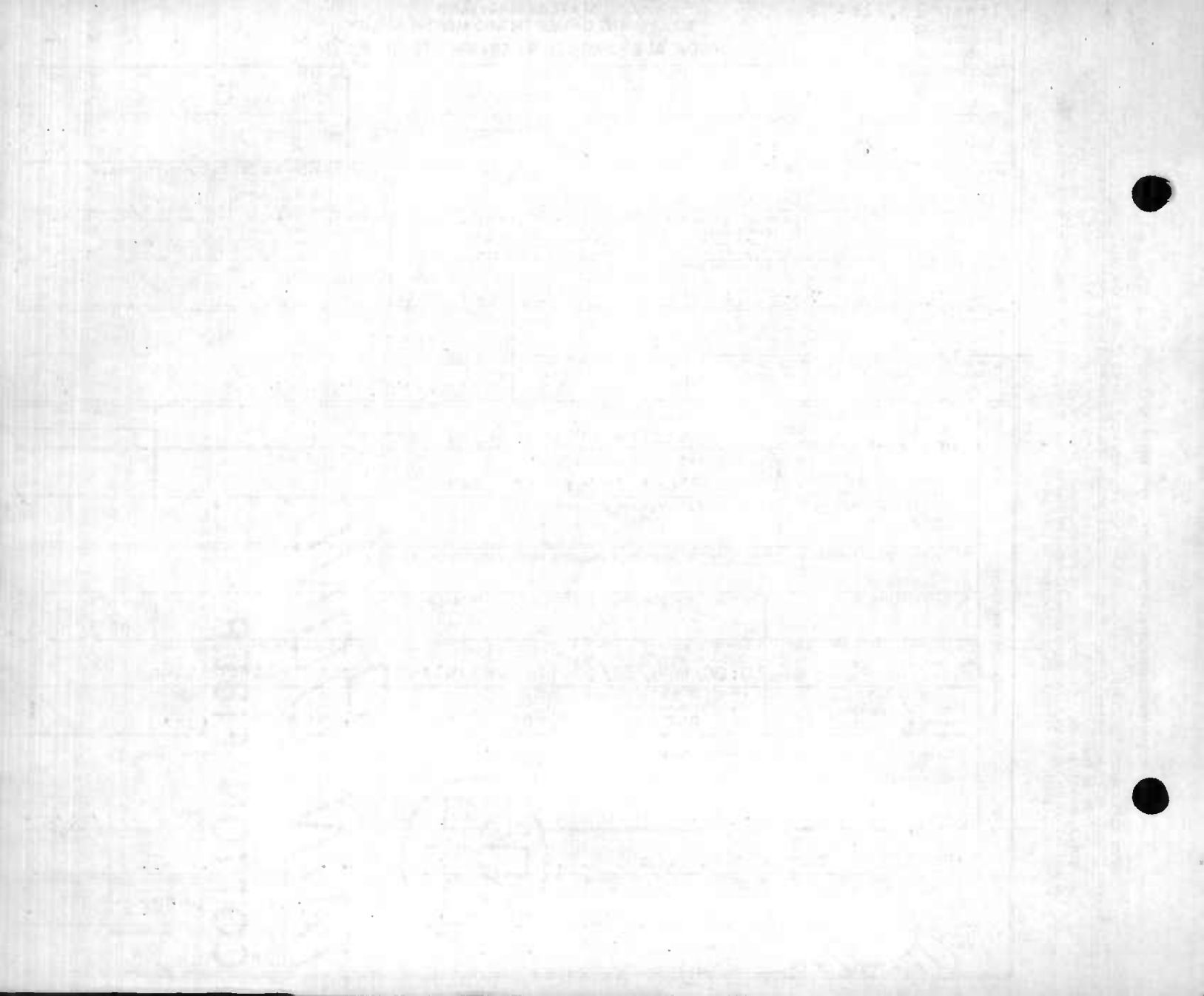
Salisbury

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM. 3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL-TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED, WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

BP

DHM - 17
(VR A15 ME (5))
30M 7/73

<div> <div> <div>18,21b-22a</div> <div>G543</div> <div>5/22/80</div> <div>STATE OF MARYLAND</div> </div> <div> <div>1-STATE</div> <div>FOR dad</div> <div>REGISTRAR</div> </div> </div> <div> <div>DEPARTMENT OF HEALTH AND MENTAL HYGIENE</div> <div>MEDICAL EXAMINER'S CERTIFICATE OF DEATH</div> </div> <div> <div>REG. NO.</div> <div>3011282</div> </div>									
1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST William J. McGee						2a. DATE KNOWN OF DEATH ESTIMATED MONTH DAY YEAR 4 23 1980		2b. HOUR M M	
3. SEX Male	4. RACE White	5. DATE OF BIRTH MONTH DAY YEAR 10-26-1911	6. AGE (IN YEARS) LAST BIRTHDAY 68 YRS.	IF UNDER 1 YR. MONTHS DAYS	IF UNDER 24 HRS. HOURS MIN.	2c. DATE PRONOUNCED DEAD MONTH DAY YEAR 4 23 1980		2d. HOUR M 12:30	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) DELAWARE		7b. CITIZEN OF WHAT COUNTRY? USA		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Wicomico County, MD.			
10. CITY OR TOWN OF DEATH Salisbury		11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Peninsula General Hospital				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) RET. CRIS CRAFT CORP.		12b. KIND OF BUSINESS OR INDUSTRY	
USUAL RESIDENCE (IF IN NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)				13a. STATE MARYLAND		13b. COUNTY WORCESTER		13c. CITY OR TOWN BISHOPVILLE	
				13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET ADDRESS BOX 58			
14. FATHER'S NAME FIRST MIDDLE LAST LEVIN JAMES MC GEE				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST LILLIE MAE MC GEE					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) NO			16b. SOCIAL SECURITY NO. 220-28-0639		17. INFORMANT ADDRESS ELLA MAE MC GEE				
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I DEATH WAS CAUSED BY: 9682 IMMEDIATE CAUSE (a) Massive subarachnoid hemorrhage DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last: (b) Blunt injury to head DUE TO, OR AS A CONSEQUENCE OF (c) APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH									
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a).									
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?					20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR 10:00pm 4/22/80		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2) assaulted during altercation				
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.) car		21f. LOCATION STREET CITY OR TOWN COUNTY STATE Back Creek Road, worcester, Md.				
22a. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> .									
ACTUAL SIGNATURE Virginia L. Dolan			TITLE (SPECIFY) M.D. Assistant MEDICAL EXAMINER					DATE SIGNED 4/24/80	
EXAMINER'S NAME (TYPE OR PRINT) Virginia L. Dolan, M.D.			ADDRESS 111 Penn St. Balto., Md.						
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) BURIAL			23b. DATE 4-17-80		23c. NAME OF CEMETERY OR CREMATORY BISHOPVILLE CEM.		23d. LOCATION CITY OR TOWN COUNTY STATE BISHOPVILLE, WORCESTER, MD.		
24. FUNERAL DIRECTOR NAME FRANKFORD, DEL.					25a. DATE REC'D. BY REGISTRAR MAY 1 1980		25b. REGISTRAR'S SIGNATURE Duffy McCreedy		



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the Registrar with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

MEDICAL CERTIFICATION

1. DECEASED NAME				2a. DATE OF DEATH				2b. HOUR			
FIRST MIDDLE LAST				MONTH DAY YEAR				MONTH DAY YEAR			
IDA W. MITCHELL				April 15 1980				5:20 PM			
3 SEX		4 RACE		5 DATE OF BIRTH		6 AGE		7a BIRTHPLACE		7b CITIZEN OF WHAT COUNTRY?	
Female		WHITE		July 9, 1889		90		MARYLAND		U.S.A.	
7a BIRTHPLACE		7b CITIZEN OF WHAT COUNTRY?		8 MARRIED		8 NEVER MARRIED		9 BALTIMORE CITY OR COUNTY OF DEATH		9 MD.	
MARYLAND		U.S.A.		WIDOWED		DIVORCED		Wicomico			
10 CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION		12a USUAL OCCUPATION		12b KIND OF BUSINESS OR INDUSTRY		13a STREET ADDRESS		13b INSIDE CITY LIMITS?	
Salisbury		Peninsula General Hospital		HOUSE-WIFE		OWN HOME		1105 Russell Ave		YES NO	
14 FATHER'S NAME		15 MOTHER'S MAIDEN NAME		16 WAS DECEASED EVER IN U.S. ARMED FORCES?		16b SOCIAL SECURITY NO		17 INFORMANT		17 ADDRESS	
Josephus Chatham		Drucilla Messick		No		214-32-6994		Drucilla M. Fox		Salisbury Md.	
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY:										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
IMMEDIATE CAUSE (a) Acute Pulmonary Edema											
DUE TO, OR AS A CONSEQUENCE OF (b) Severe Coronary Artery Disease											
DUE TO, OR AS A CONSEQUENCE OF (c)											
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)											
Chronic Obstructive Lung Disease											
19a DATE OF OPERATION				19b CONDITION FOR WHICH OPERATION WAS PERFORMED				20a AUTOPSY?		20b IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?	
								YES NO		YES NO	
21a ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH				21b TIME OF INJURY				21c HOW INJURY OCCURRED			
(IF EITHER, NOTIFY MEDICAL EXAMINER)				HOUR A.M. MONTH DAY YEAR				(ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)			
				P.M. 19							
21d INJURY OCCURRED				21a PLACE OF INJURY				21i LOCATION			
WHILE AT WORK NOT WHILE AT WORK				(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)				STREET CITY OR TOWN COUNTY STATE			
22a I certify that (I) (this hospital) attended the deceased from 4/13/80, to 4/15/80, that (I) (we) last saw the deceased alive on 4/15/80, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.											
22b SIGNATURE				DEGREE				22c DATE SIGNED			
Benito S. Chan MD				ATTENDING PHYSICIAN				4/15/80			
22d PHYSICIAN'S NAME (TYPE OR PRINT)				22e ADDRESS							
BENITO S. CHAN				577-D Riverside Drive, Salisbury							
23a BURIAL CREMATION, REMOVAL				23b DATE				23c NAME OF CEMETERY OR CREMATORY			
BURIAL				4/17/1980				PARSONS CEM.			
23d LOCATION				23e DATE REC'D. BY REGISTRAR				23f REGISTRAR'S SIGNATURE			
SALISBURY MD				APR 21 1980				Jeffrey McCreedy			

10-10-10

Penitentiary General Hospital

Salisbury

March 10 - 1910

Chas. W. Smith

No. 1 - 2nd Street

**FOR STATE
HEALTH DEPT.**

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

11284

1. DECEASED-NAME (Type or Print)			First Jack			Middle P.			Last Morris			2a. DATE KNOWN OF DEATH MATED <input checked="" type="checkbox"/> 4-9 1980			2b. HOUR 1230 A M								
3. SEX M		4. RACE W		5. DATE OF BIRTH 5-24-13		6. AGE (In years last birthday) 66 YRS.		IF UNDER 1 YEAR MONTHS <input type="checkbox"/> DAYS <input type="checkbox"/>		IF UNDER 24 HRS HOURS <input type="checkbox"/> MIN. <input type="checkbox"/>		2c. DATE PRONOUNCED DEAD Month 4 Day 9 Year 1980			2d. HOUR 156 A M								
7a. BIRTHPLACE (State or foreign country) Maryland			7b. CITIZEN OF WHAT COUNTRY? USA			8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>			9. COUNTY OF DEATH Wicomico														
10. CITY OR TOWN OF DEATH Salisbury				11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) Peninsula General Hsp.				12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) Farmer				12b. KIND OF BUSINESS OR INDUSTRY Poultry											
13a. USUAL RESIDENCE (Where deceased admission) STATE md.				13b. COUNTY Wicomico				13c. CITY OR TOWN Salisbury		13d. INSIDE CITY LIMITS YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET AND NUMBER 255 Glen Ave.											
14. FATHER'S NAME			First Leonard			Middle Morris			Last Parker			15. MOTHER'S MAIDEN NAME			First Irma			Middle Parker			Last		
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) NO				(If yes give war or dates of service)				16b. SOCIAL SECURITY NO. 217-28-3293				17. INFORMANT ADDRESS											
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)																APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH							
PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Coronary Occlusion																Sudden							
DUE TO, OR AS A CONSEQUENCE OF (b) ASCVD																year							
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.																							
DUE TO, OR AS A CONSEQUENCE OF (c)																							
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)																							
19a. DATE OF OPERATION						19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?						20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>											
21a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH				21b. TIME OF INJURY Month, Day, Year HOUR A.M. 19 P.M.				21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)															
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>				21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.)				21f. LOCATION Street or R.F.D. No.				City or Town				County				State			
22a. I certify that I took charge of the remains described above, held on Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>																							
ACTUAL SIGNATURE Earl L. Royer				M.D.				CHIEF MEDICAL EXAMINER <input type="checkbox"/>				ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>				DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>				22b. DATE SIGNED 4-9-80			
EXAMINER'S NAME (Type) Earl L. Royer				Salisbury				ADDRESS (Street, city, town, and county) Wicomico															
23a. BURIAL (CREMATION, REMOVAL) (Specify)				23b. DATE 4-9-1980				23c. NAME OF CEMETERY OR CREMATORY				23d. LOCATION (City or Town) (County) (State)											
24. FUNERAL DIRECTOR								ADDRESS								25a. REC'D BY REGISTRAR DATE APR 21 1980				25b. REGISTRAR'S SIGNATURE W. H. H. H.			
ANATOMY BOARD OF MD, BALTIMORE, MD.																							

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death, any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Page 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

Information

Plant Industry Circular No. 100

February

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, this page should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 24 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE				8 0 1 1 2 8 5	
1- FOR STATE REGISTRAR				REG. NO.	
1. DECEASED NAME (TYPE OR PRINT) Kenneth LaMar MUSSEY			2a. DATE OF DEATH MONTH DAY YEAR APRIL 1 1980		2b. HOUR 1:30 P.M.
3. SEX Male	4. RACE White	5. DATE OF BIRTH MONTH DAY YEAR Feb. 13, 1938		6. AGE (IN YEARS LAST BIRTHDAY) 42 YRS.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Troxellville, Pa.	7b. CITIZEN OF WHAT COUNTRY? USA	8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Wicomico MD.	
10. CITY OR TOWN OF DEATH Salisbury	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Peninsula General Hospital		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Dist. Manager		12b. KIND OF BUSINESS OR INDUSTRY Auto Parts
13a. STATE Maryland			13b. COUNTY Wicomico	13c. CITY OR TOWN Salisbury	13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>
14. FATHER'S NAME FIRST MIDDLE LAST Marsden Herbert Musser			15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Erma May Kratzer		
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No		16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) 193-28-1860		17. INFORMANT ADDRESS Mrs. Mary E. Musser (wife) same as 13	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY. IMMEDIATE CAUSE (a) Carcinoma of the lung 1629 DUE TO, OR AS A CONSEQUENCE OF (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.					APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 8 months
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a):					
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 19, PART 1 OR PART 2)	
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE	
22a. I certify that (I) (this hospital) attended the deceased from March 30 , 19 80 , to April 1 , 19 80 , that (I) (we) <input checked="" type="checkbox"/> saw the deceased alive on March 31 + April 1 , 19 80 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (If not, state date and hour of death.)					
22b. SIGNATURE Rayson Jr		DEGREE MD ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED 4-1-80	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) C. R. Layton Jr		22e. ADDRESS PCHMC Salisbury			
23a. BURIAL, CREMATION, REMOVAL Burial		23b. DATE 4/5/80		23c. NAME OF CEMETERY OR CREMATORY Wicomico Memorial Park	
23d. LOCATION CITY OR TOWN COUNTY STATE Salisbury, Wicomico, Maryland		25a. DATE REC'D. BY REGISTRAR		25b. REGISTRAR'S SIGNATURE Holloway	
24. FUNERAL DIRECTOR NAME HOLLOWAY FUNERAL HOME, Salisbury, Md.		ADDRESS		25c. DATE REC'D. BY REGISTRAR APR 3 1980	

1 APRIL 1980

Salisbury Penitentiary General Hospital

APR 1 1980

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH				8 0 1 1 2 8 6			
1. FOR STATE REGISTRAR				REG. NO.			
1. DECEASED NAME (TYPE OR PRINT) Malinda Nock				2a. DATE OF DEATH MONTH DAY YEAR April 10, 1980		2b. HOUR 8:00 P M	
3. SEX Female		4. RACE Negro		5. DATE OF BIRTH MONTH DAY YEAR June 11, 1897		6. AGE (IN YEARS LAST BIRTHDAY) 82 YRS	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Md.		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Wicomico MD.	
10. CITY OR TOWN OF DEATH Salisbury		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Peninsula General Hospital		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Laborer		12b. KIND OF BUSINESS OR INDUSTRY Factory	
13a. STATE Md. 13b. COUNTY Somerset 13c. CITY OR TOWN Pocomoke				13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET ADDRESS R.F.D. I Bx. 387	
14. FATHER'S NAME FIRST MIDDLE LAST William H. Hayward				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Hester York			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No				16b. SOCIAL SECURITY NO. 900-11-2445		17. INFORMANT ADDRESS Heroy Hayward R.F.D. Bx 146 Marion, Md.	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Cardiac arrest 5939 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last DUE TO, OR AS A CONSEQUENCE OF (b) Renal insufficiency DUE TO, OR AS A CONSEQUENCE OF (c)							APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)							
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)			
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22a. I certify that (I) (this hospital) attended the deceased from _____, 19_____, to _____, 19_____, that (I) (we) lost saw the deceased alive on _____, 19_____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.							
22b. SIGNATURE G. Well				DEGREE		22c. DATE SIGNED 4-11-80	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) Edward G. Well				22e. ADDRESS R.G.H.			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE 4-14-80		23c. NAME OF CEMETERY OR CREMATORY Baggs Cem.		23d. LOCATION CITY OR TOWN COUNTY STATE Pocomoke Wic. Md.	
24. FUNERAL DIRECTOR James				25a. DATE REC'D. BY REGISTRAR APR 22 1980		25b. REGISTRAR'S SIGNATURE Henry McCready	

Mr. [Name] [Address]
[City] [State] [Zip]
[Phone Number]
[Email Address]
[Date]
[Subject]
[Body of letter]
[Signature]
[Enclosure]

[Additional text or signature block]

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH				8 0 1 1 2 8 7			
1. FOR STATE REGISTRAR				REG. NO.			
1. DECEASED NAME (TYPE OR PRINT) <u>JESSE MILTON PARKER</u>				2a. DATE OF DEATH MONTH DAY YEAR <u>APRIL 18 1980</u>		2b. HOUR <u>11 30</u> M	
3 SEX <u>MALE</u>		4 RACE <u>WHITE</u>		5 DATE OF BIRTH MONTH DAY YEAR <u>MAY 26, 1901</u>		6 AGE (IN YEARS LAST BIRTHDAY) <u>78</u> YRS	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <u>MARYLAND</u>		7b. CITIZEN OF WHAT COUNTRY? <u>U. S. A.</u>		8 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9 BALTIMORE CITY OR COUNTY OF DEATH <u>Wicomico</u> MD	
10 CITY OR TOWN OF DEATH <u>Salisbury</u>		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <u>Peninsula General Hospital</u>		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <u>EXECUTIVE RET</u>		12b. KIND OF BUSINESS OR INDUSTRY <u>BANKING</u>	
USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE <u>MD</u> 13b. COUNTY <u>Wico.</u> 13c. CITY OR TOWN <u>SALISBURY</u>				13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET ADDRESS <u>2809 Ocean City Rd</u>	
14 FATHER'S NAME FIRST MIDDLE LAST <u>J. MILTON PARKER</u>				15 MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <u>ROSANNA Fooks</u>			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <u>No</u>		16b. SOCIAL SECURITY NO (IF YES, GIVE WAR OR DATES) <u>215-187660</u>		17 INFORMANT ADDRESS <u>MARGIE DENNIS PARKER, Same</u>			
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Carcinoma of Prostate with</u> <u>185-</u> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last (b) <u>Metastases</u> DUE TO, OR AS A CONSEQUENCE OF (c) _____ APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <u>16 mos</u>							
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) _____							
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)			
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22a. I certify that (I) <u>this hospital</u> attended the deceased from <u>April 2</u> 19 <u>80</u> , to <u>April 18</u> 19 <u>80</u> , that (I) <u>was</u> lost saw the deceased alive on <u>April 18</u> 19 <u>80</u> , and that in (my) <u>best</u> opinion death occurred on the date and hour and from the causes stated above, (I) <u>was</u> (did) (did not) view the body after death.							
22b. SIGNATURE <u>Thomas C Hill Jr</u>				DEGREE <u>M.D.</u>		22c. DATE SIGNED <u>4/18/80</u>	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <u>THOMAS C. Hill Jr</u>				22e. ADDRESS <u>Pine Bluff Road, Salisbury Md</u>			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>BURIAL</u>		23b. DATE <u>4/21/1980</u>		23c. NAME OF CEMETERY OR CREMATORY <u>PARSONS Cem.</u>		23d. LOCATION CITY OR TOWN COUNTY STATE <u>Salisbury Md</u>	
24 FUNERAL DIRECTOR NAME <u>Hill-Barker-Bounds</u> ADDRESS <u>Salisbury Md</u>				25a. DATE REC'D BY REGISTRAR <u>APR 22 1980</u>		25b. REGISTRAR'S SIGNATURE <u>[Signature]</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Pages 1 and 2 should be filed within 72 hours after death. The law requires that the death certificate be executed within 24 hours after death. Pages 1 and 2 should be filed within 72 hours after death.

DHMM-16 25M
(VRA 15, 4) 1/79

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH				8 0 1 1 2 8 8			
1. FOR STATE REGISTRAR				REG. NO.			
1. DECEASED NAME (TYPE OR PRINT) Roy A. PARSONS				2a. DATE OF DEATH MONTH DAY YEAR APRIL 8 1980		2b. HOUR 8A. M.	
3. SEX M		4. RACE W		5. DATE OF BIRTH MONTH DAY YEAR July 20, 1905		6. AGE (IN YEARS LAST BIRTHDAY) 74 YRS	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Delaware		7b. CITIZEN OF WHAT COUNTRY? USA		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Wicomico MD.	
10. CITY OR TOWN OF DEATH Salisbury		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION Peninsula General Hospital		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) maintenance		12b. KIND OF BUSINESS OR INDUSTRY Del St Hgy Dt.	
13a. STATE Delaware		13b. COUNTY Sussex		13c. CITY OR TOWN Delmar		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
14. FATHER'S NAME FIRST MIDDLE LAST Elezar Parsons		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Mary Ward		16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) no		16b. SOCIAL SECURITY NO. 222 05 3578	
17. INFORMANT George A. Parsons				ADDRESS rd2 Laurel, Del. 19956			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Epidemic meningitis of lung 1629 DUE TO, OR AS A CONSEQUENCE OF (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last						APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a):							
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)			
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22a. I certify that (I) (this hospital) attended the deceased from 3/25 , 19 80 , to 4/8 , 19 80 , that (I) (was) last saw the deceased alive on 4/7 , 19 80 , and that in (my) (her) opinion death occurred on the date and hour and from the causes stated above, (I) (was) (did) (did not) view the body after death.							
22b. SIGNATURE [Signature]				DEGREE M.D.		22c. DATE SIGNED 4/8/80	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) Joseph A. GRASSO				22e. ADDRESS 1300 S. Division St Smisway Md.			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) burial		23b. DATE 4/11/80		23c. NAME OF CEMETERY OR CREMATORY Laurel Hill Cemetery		23d. LOCATION CITY OR TOWN COUNTY STATE Laurel Sussex Delaware	
24. FUNERAL DIRECTOR NAME Homer L. Disharoon				ADDRESS box 678 Laurel Del 19956		25a. DATE REC'D. BY REGISTRAR APR 11 1980	
				25b. REGISTRAR'S SIGNATURE [Signature]			

1777

Benjamin Franklin

Philadelphia

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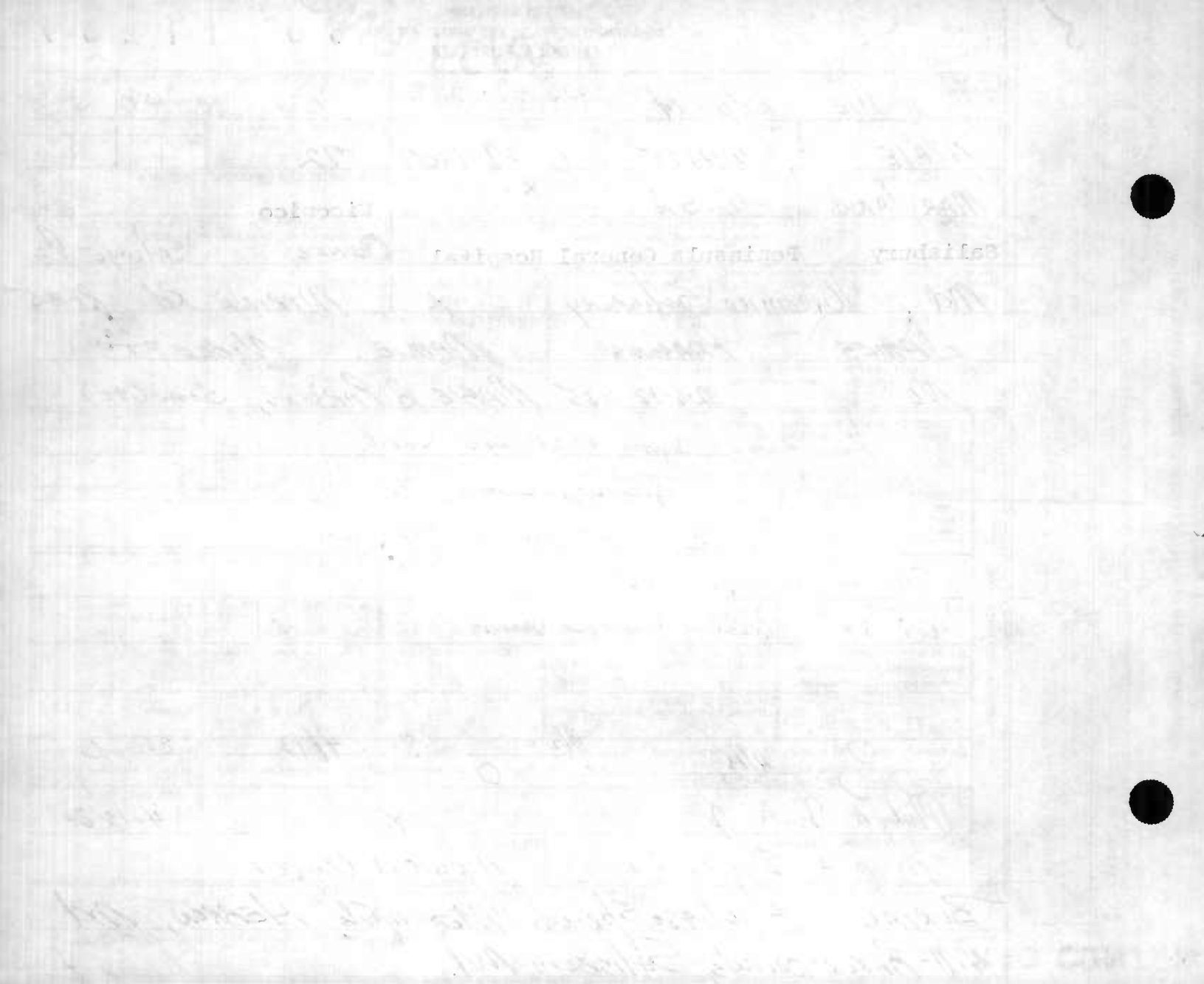
TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. It must be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If Item 21 is marked or Item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH				8 0 1 1 2 8 9			
1. FOR STATE REGISTRAR				REG. NO.			
1. DECEASED NAME (TYPE OR PRINT) WILLIE EDWARD PARSONS				2a. DATE OF DEATH MONTH DAY YEAR April 13 1980			
3. SEX MALE				2b. HOUR 4:58 PM			
4. RACE WHITE		5. DATE OF BIRTH MONTH DAY YEAR 6-27-1907		6. AGE (IN YEARS LAST BIRTHDAY) 72 YRS.		7. IF UNDER 1 YEAR MONTHS DAYS	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) MARYLAND		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Wicomico MD.	
10. CITY OR TOWN OF DEATH Salisbury		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Peninsula General Hospital		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) OWNER		12b. KIND OF BUSINESS OR INDUSTRY Salvage Co	
13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13b. STATE MD. 13c. COUNTY Wicomico 13d. CITY OR TOWN Salisbury				13e. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
14. FATHER'S NAME FIRST MIDDLE LAST CLAYTON PARSONS				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST MAMIE NIBLETT			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) NO		16b. SOCIAL SECURITY NO 216-12-1025		17. INFORMANT ADDRESS MAMIE B. PARSONS, Same (BC)			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Sepsis & Cardiac Shock.							APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
5715 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. DUE TO, OR AS A CONSEQUENCE OF (b) Bronchopneumonia							
DUE TO, OR AS A CONSEQUENCE OF (c) Advanced carcinoma of the liver							
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) Bleeding esophageal varices							
19a. DATE OF OPERATION 4-8-80		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED Bleeding esophageal varices		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)			
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22a. I certify that (1) (this hospital) attended the deceased from 3/22 19 80 , to 4/13 19 80 , that (1) (we) lost saw the deceased alive on 4/13 19 80 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (1) (we) (did) (did not) view the body after death.							
22b. SIGNATURE Philip A Insley Jr				DEGREE Medical Center		22c. DATE SIGNED 4-13-80	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) Philip A Insley Jr				22e. ADDRESS Medical Center			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) BURIAL		23b. DATE 4/16/1980		23c. NAME OF CEMETERY OR CREMATORY Springhill Memory Co		23d. LOCATION CITY OR TOWN Hebron COUNTY MD STATE	
24. FUNERAL DIRECTOR NAME Hill-Baker-Bondz ADDRESS Salisbury Md.				25a. DATE RECEIVED BY REGISTRAR APR 1 1980 25b. REGISTRAR'S SIGNATURE [Signature]			



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH				8011290			
1. FOR STATE REGISTRAR				REG. NO.			
1. DECEASED NAME (TYPE OR PRINT) Norman James PERDUE				2a. DATE OF DEATH MONTH DAY YEAR APRIL 13, 1980		2b. HOUR 12 ⁴⁰ P. M.	
3 SEX Male		4 RACE White		5. DATE OF BIRTH MONTH DAY YEAR July 17, 1905		6. AGE (IN YEARS LAST BIRTHDAY) 74 YRS.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Maryland		7b. CITIZEN OF WHAT COUNTRY? USA		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Wicomico MD.	
10. CITY OR TOWN OF DEATH Salisbury		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Peninsula General Hospital		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Carpenter		12b. KIND OF BUSINESS OR INDUSTRY Construction	
13a. STATE Maryland		13b. COUNTY Wicomico		13c. CITY OR TOWN Salisbury		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>	
14. FATHER'S NAME FIRST MIDDLE LAST Purnell Perdue		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Charlotte Ann Smith		16. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES) No			
17. SOCIAL SECURITY NO. 217-16-9054		18. INFORMANT ADDRESS Mrs. Ruth Perdue (wife) same as 13					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Refractory Congestive Failure</u> 4149 DUE TO, OR AS A CONSEQUENCE OF (b) <u>Coronary Artery Disease</u> DUE TO, OR AS A CONSEQUENCE OF (c) <u>atherosclerosis</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 48 hr 4 mo 10.3 yr							
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)							
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)			
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22a. I certify that (I) (this hospital) attended the deceased from <u>4/13/80</u> , 19 <u>80</u> , to <u>4/13/80</u> , 19 <u>80</u> , that (I) (we) last saw the deceased alive on <u>4/13/80</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (If I (we) did not view the body after death.)							
22b. SIGNATURE <u>R. J. F. T. D.</u>				DEGREE <u>M.D.</u>		22c. DATE SIGNED 4/15/80	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) R. J. F. T. D.				22e. ADDRESS Quincy & Locust St. Salisbury Md			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE 4/16/80		23c. NAME OF CEMETERY OR CREMATORY Bethel Cemetery		23d. LOCATION CITY OR TOWN COUNTY STATE Walston, Wic., Maryland	
24. FUNERAL DIRECTOR HOLLOWAY FUNERAL HOME, Salisbury, Md.				25a. DATE REC'D. BY REGISTRAR APR 17 1980		25b. REGISTRAR'S SIGNATURE <u>John J. McCready</u>	

BP

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Bellevue General Hospital

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TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR FOR PAGE 4. SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PA 3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL/TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED, WITHIN 24 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

BP
DHMH-17
(VR A15 ME (5))
30M 7/73

FOR 1- STATE REGISTRAR												STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE MEDICAL EXAMINER'S CERTIFICATE OF DEATH												REG. NO. 11291									
1. DECEASED NAME (TYPE OR PRINT)						FIRST MIDDLE LAST						2a. DATE KNOWN OF DEATH				2b. DATE OF ESTI- MATED				2c. DATE PRONOUNCED DEAD				2d. HOUR									
Nathaniel G. Perry												4-15-80				10:30 AM				11:15 PM													
3. SEX		4. RACE		5. DATE OF BIRTH		6. AGE (IN YEARS)		IF UNDER 1 YR.		IF UNDER 24 HRS.		7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)				7b. CITIZEN OF WHAT COUNTRY?				8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>				9. BALTIMORE CITY OR COUNTY OF DEATH									
Male		Black		9 18 27 52		YRS.		MONTHS		DAYS		Md.				U.S.				Wicomico													
10. CITY OR TOWN OF DEATH						11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION						12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING TIME)						12b. KIND OF BUSINESS OR INDUSTRY															
Salisbury						Annis. Lab. Gen. Hosp. McEnt						Seafood																					
13a. STATE						13b. COUNTY						13c. CITY OR TOWN						13d. INSIDE CITY LIMITS?						13e. STREET ADDRESS									
Md.						Wicomico						Nanticoke						YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>						Bank Rd.									
14. FATHER'S NAME						15. MOTHER'S MAIDEN NAME						16a. WAS DECEASED EVER IN U.S. ARMED FORCES?						16b. SOCIAL SECURITY NO.						17. INFORMANT ADDRESS									
George Samuel Perry						Senora Jones						No						213-24-1995						Ota Perry, Nanticoke, Md.									
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)												APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH																					
PART I DEATH WAS CAUSED BY:												30 min																					
IMMEDIATE CAUSE (a) Myocardial Infarction																																	
410- Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last.																																	
DUE TO, OR AS A CONSEQUENCE OF																																	
(b) Arteriosclerotic Heart Disease												years																					
DUE TO, OR AS A CONSEQUENCE OF																																	
(c)																																	
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a).																																	
19a. DATE OF OPERATION						19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?																		20. AUTOPSY?									
																								YES <input type="checkbox"/> NO <input type="checkbox"/>									
21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH						21b. TIME OF INJURY						21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)																					
						P.M. 19																											
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>						21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)						21f. LOCATION																					
												CITY OR TOWN COUNTY STATE																					
22a. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> .																																	
ACTUAL SIGNATURE												TITLE (SPECIFY)												DATE SIGNED									
John T. Bulkeley												Deputy												4-16-80									
EXAMINER'S NAME (TYPE OR PRINT)												ADDRESS												21801									
John T. Bulkeley												Salisbury, Maryland																					
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)						23b. DATE						23c. NAME OF CEMETERY OR CREMATORY						23d. LOCATION															
Burial						4/19/80						Nanticoke Cem.						Nanticoke, Md.															
24. FUNERAL DIRECTOR												25a. DATE REC'D. BY REGISTRAR												25b. REGISTRAR'S SIGNATURE									
E. M. Mearns												APR 21 1980												[Signature]									

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Date: 12-15-1911
Page: 1

Winnipeg

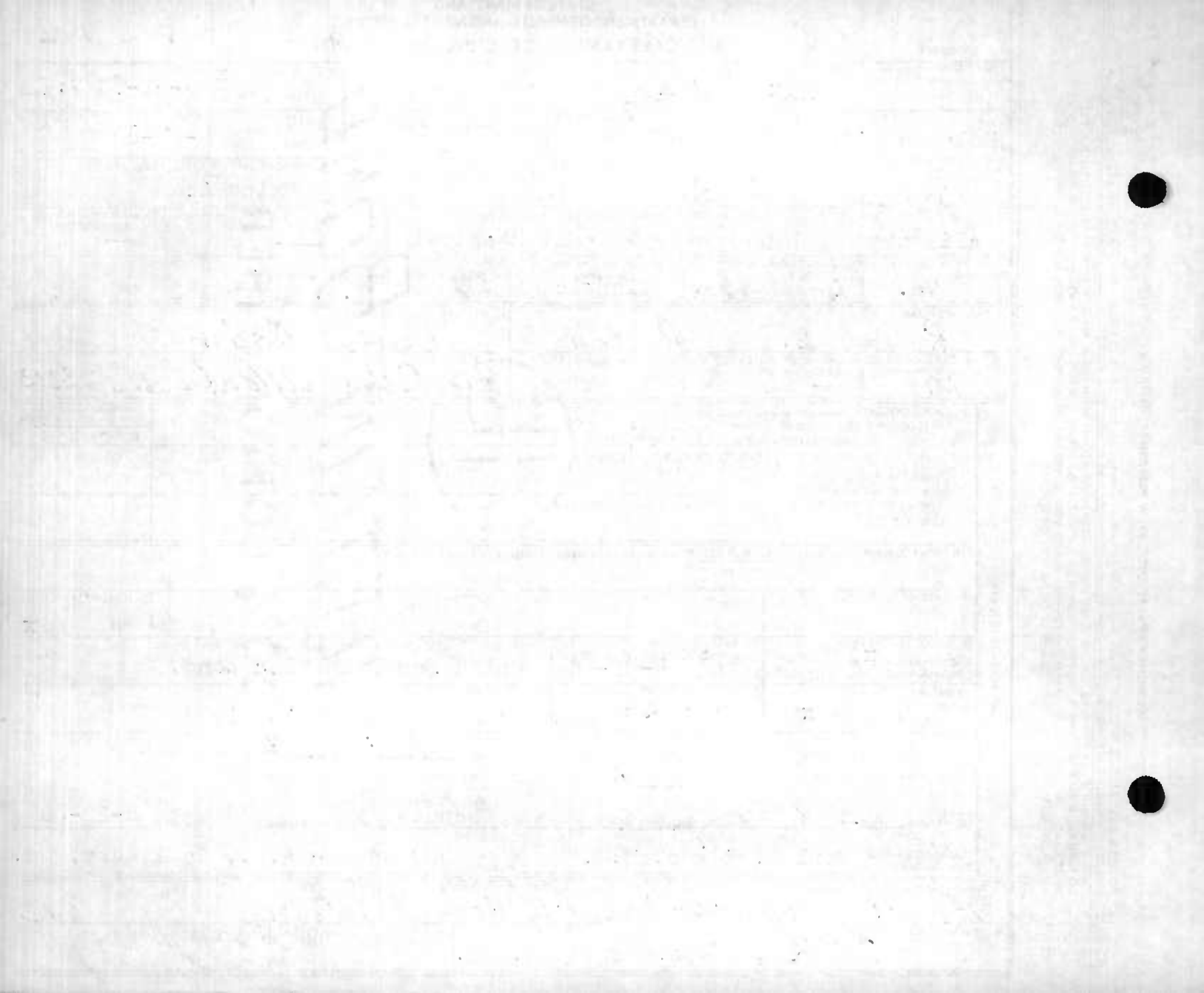
TO: Mr. J. H. ...
FROM: Mr. J. H. ...

12-15-1911
J. H. ...

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, THE MEDICAL EXAMINER SHOULD EXECUTE THE CERTIFICATE, WRITING TO THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. GIVE PAGE 4 TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM. 3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL-TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED WITHIN 72 HOURS AFTER DEATH. WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

BP
DHMH-17
(VR A15 ME (5))
30M 7/73

FOR 1- STATE REGISTRAR										STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE MEDICAL EXAMINER'S CERTIFICATE OF DEATH										REG. NO. 11292			
1. DECEASED NAME (TYPE OR PRINT) RYAN Lee POSTON										2a. DATE KNOWN OF DEATH <input checked="" type="checkbox"/> ESTI. MATED <input type="checkbox"/> 4-21-80										2b. HOUR OF DEATH 7:52P			
3. SEX Male		4. RACE White		5. DATE OF BIRTH MONTH 7 DAY 18 YEAR 78		6. AGE (IN YEARS) LAST BIRTHDAY 1 YRS.		IF UNDER 1 YR. MONTHS 1 DAYS 18		IF UNDER 24 HRS. HOURS 18 MIN 52		7c. DATE PRONOUNCED DEAD 4-21-80										7d. HOUR 11	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Virginia				7b. CITIZEN OF WHAT COUNTRY? U.S.A.				8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>				9. BALTIMORE CITY OR COUNTY OF DEATH Wicomico										MD.	
10. CITY OR TOWN OF DEATH Salisbury				11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Peninsula General Hospital								12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)				12b. KIND OF BUSINESS OR INDUSTRY							
13a. STATE Va.										13b. COUNTY Accomack		13c. CITY OR TOWN Atlantic		13d. INSIDE CITY LIMITS? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO		13e. STREET ADDRESS P.O. Box 62162							
14. FATHER'S NAME FIRST R. MIDDLE L. LAST Poston										15. MOTHER'S MAIDEN NAME FIRST Leita MIDDLE Adair LAST Poston													
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) NO				16b. SOCIAL SECURITY NO. ---				17. INFORMANT ADDRESS R.L. Poston Atlantic Va 23303															
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1 DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Drowning 79109 Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last. (b) (c) DUE TO, OR AS A CONSEQUENCE OF DUE TO, OR AS A CONSEQUENCE OF DUE TO, OR AS A CONSEQUENCE OF														APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH minutes									
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a).																							
19a. DATE OF OPERATION				19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?										20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>									
21a. EXTERNAL CAUSE WAS UNDERLYING <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH				21b. TIME OF INJURY HOUR 5:30 MONTH 4 DAY 21 YEAR 80				21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2) Child found in fish pond.															
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input checked="" type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK				21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.) fish pond near home				21f. LOCATION STREET Atlantic CITY OR TOWN Atlantic COUNTY Atlantic STATE Va.															
22a. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and in my opinion death resulted from: Natural causes <input type="checkbox"/> , Accident <input checked="" type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/> .																							
ACTUAL SIGNATURE <i>Earl L. Royer</i>				TITLE (SPECIFY) Deputy				DATE SIGNED 4-22-80				MEDICAL EXAMINER											
EXAMINER'S NAME (TYPE OR PRINT) Earl L. Royer, M.D.				ADDRESS 409 Camden Ave., Salisbury, Md.																			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial				23b. DATE 4-24-1980		23c. NAME OF CEMETERY OR CREMATORY Lake City Memorial				23d. LOCATION CITY OR TOWN Lake City COUNTY S.C. STATE S.C.													
24. FUNERAL DIRECTOR NAME Fox Funeral Home				ADDRESS Temperanceville, Va.				25a. DATE REC'D. BY REGISTRAR APR 23 1980				25b. REGISTRAR'S SIGNATURE <i>[Signature]</i>											



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, pages should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH				8011293			
1- FOR STATE REGISTRAR				REG. NO.			
1 DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST Thomas C. Potter Sr.				2a DATE OF DEATH MONTH DAY YEAR April 3, 1980		2b HOUR MIN 1:30 AM	
3 SEX Male		4 RACE Cau.		5 DATE OF BIRTH MONTH DAY YEAR Dec. 10, 1906		6 AGE (IN YEARS LAST BIRTHDAY) YRS. MONTHS DAYS 73	
7a BIRTHPLACE (STATE OR FOREIGN COUNTRY) Cambridge, Md.		7b CITIZEN OF WHAT COUNTRY? U.S.A.		8 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9 BALTIMORE CITY OR COUNTY OF DEATH Wicomico MD.	
10 CITY OR TOWN OF DEATH Salisbury		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Peninsula General Hospital		12a USUAL OCCUPATION (TYPE OF WORK OR MAIN EARNING (IFE) construction		12b KIND OF BUSINESS OR INDUSTRY boat builder	
13a USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13b STATE 13c CITY OR TOWN Md. Dorchester Cambridge				13d INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e STREET ADDRESS 421 Henry St.	
14 FATHER'S NAME FIRST MIDDLE LAST Everett Potter				15 MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Hattie Hurley			
16a WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES) no		16b SOCIAL SECURITY NO. 220-10-6060		17 INFORMANT ADDRESS Mrs. T.C.Potter, Sr. (same as 13e)			
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>RESPIRATORY ARREST</u> <u>4279</u> DUE TO, OR AS A CONSEQUENCE OF (b) <u>MASSIVE STROKE</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost DUE TO, OR AS A CONSEQUENCE OF (c) <u>VENTRICULAR FIBRILLATION & HEART FAILURE</u>						APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <u>30 min.</u> <u>4 DAYS</u> <u>4 DAYS</u>	
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a)							
19a DATE OF OPERATION		19b CONDITION FOR WHICH OPERATION WAS PERFORMED		20a AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)			
21d INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK		21e PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f LOCATION STREET CITY OR TOWN COUNTY STATE			
22a I certify that (I) (this hospital) attended the deceased from <u>3/21</u> , 19 <u>80</u> , to <u>4/3</u> , 19 <u>80</u> , that (I) (we) lost saw the deceased alive on <u>4/2</u> , 19 <u>80</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.							
22b SIGNATURE <u>E. H. KLOPP MD.</u> DEGREE				22c DATE SIGNED <u>4/3/80</u>			
22d PHYSICIAN'S NAME (TYPE OR PRINT) E. H. KLOPP				22e ADDRESS STR 25. MED. CTR. WRTST. SALISBURY, MD			
23a BURIAL, CREMATION, REMOVAL (SPECIFY) burial		23b DATE April 5, 1980		23c NAME OF CEMETERY OR CREMATORY East New Market		23d LOCATION CITY OR TOWN COUNTY STATE Dor., Md.	
24 FUNERAL DIRECTOR NAME Curran Funeral Home, Cambridge, Md.				25a DATE REC'D. BY REGISTRAR APR 9 1980		25b REGISTRAR'S SIGNATURE <u>[Signature]</u>	



Dec. 11, 1966

Cambridge, Mass.

Cambridge, Mass. General Hospital

Cambridge, Mass. General Hospital

Cambridge, Mass. General Hospital

220-10-0000 Mrs. T.C. Carter, Jr. (name as 196)

APR 2 1960
APR 2 1960
APR 2 1960

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 must be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, pages 1 and 2 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after the death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH									
1. FOR STATE REGISTRAR			REG. NO. 80 11294						
1 DECEASED NAME (TYPE OR PRINT)			FIRST MIDDLE LAST			2a DATE OF DEATH MONTH DAY YEAR			2b. HOUR
Gertrude Susan			Ridgell			April 1, 1980			3:45 P.M.
3 SEX		4 RACE		5 DATE OF BIRTH MONTH DAY YEAR		6 AGE (IN YEARS LAST BIRTHDAY)		7 IF UNDER 1 YEAR IF UNDER 24 HRS	
Female		White		April 27, 1901		78 YRS.		MONTHS DAYS HOURS MIN.	
7a BIRTHPLACE (STATE OR FOREIGN COUNTRY)		7b CITIZEN OF WHAT COUNTRY?		8 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9 BALTIMORE CITY OR COUNTY OF DEATH			
Wilmington, Del.		USA				Wicomico MD			
10 CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)				12a USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		12b KIND OF BUSINESS OR INDUSTRY	
Salisbury		Peninsula General Hospital				Assembler		Net Mfg. Co.	
USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)					13a INSIDE CITY LIMITS?				
13a STATE 13b COUNTY 13c CITY OR TOWN					YES <input type="checkbox"/> NO <input type="checkbox"/>				
Maryland Wicomico Salisbury					13a STREET ADDRESS				
					Rt. 5, Quantico Road				
14 FATHER'S NAME FIRST MIDDLE LAST					15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST				
Charles Oliver Mullen					Laura Stinson				
16a WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)			16b SOCIAL SECURITY NO.		17 INFORMANT ADDRESS				
NO			213-14-5779		Mrs. Betty Margaret Willey same as 13				
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY. IMMEDIATE CAUSE (a) <u>Cardiopulmonary arrest</u>								APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
2500 DUE TO, OR AS A CONSEQUENCE OF (b) <u>Acute Heart Failure and Pneumonia; Acute Renal Failure</u>									
DUE TO, OR AS A CONSEQUENCE OF (c) <u>Diabetes, Chronic Renal Insufficiency</u>									
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 11a									
19a DATE OF OPERATION			19b CONDITION FOR WHICH OPERATION WAS PERFORMED			20a AUTOPSY?		20b IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?	
						YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19			21c HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)			
21d INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>			21e PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)			21f LOCATION STREET CITY OR TOWN COUNTY STATE			
22a I certify that (I) (this hospital) attended the deceased from _____, 19_____, to _____, 19_____, that (I) (we) last saw the deceased alive on _____, 19_____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.									
22b SIGNATURE <u>J. A. Abramson</u>					DEGREE <u>M.D.</u>			22c DATE SIGNED <u>4/1/80</u>	
22d PHYSICIAN'S NAME (TYPE OR PRINT)					22e ADDRESS				
					Salisbury, Maryland				
23a BURIAL, CREMATION, REMOVAL (SPECIFY)			23b DATE		23c NAME OF CEMETERY OR CREMATORY		23d LOCATION CITY OR TOWN COUNTY STATE		
Burial			4/5/80		Baltimore Cemetery Co., Baltimore,		Maryland		
24 FUNERAL DIRECTOR NAME ADDRESS					25a DATE REC'D. BY REGISTRAR		25b REGISTRAR'S SIGNATURE		
HOLLOWAY FUNERAL HOME, Salisbury, Md.					APR 7 1980		<u>Robert Holloway</u>		

April 1, 1950

Peninsula General Hospital

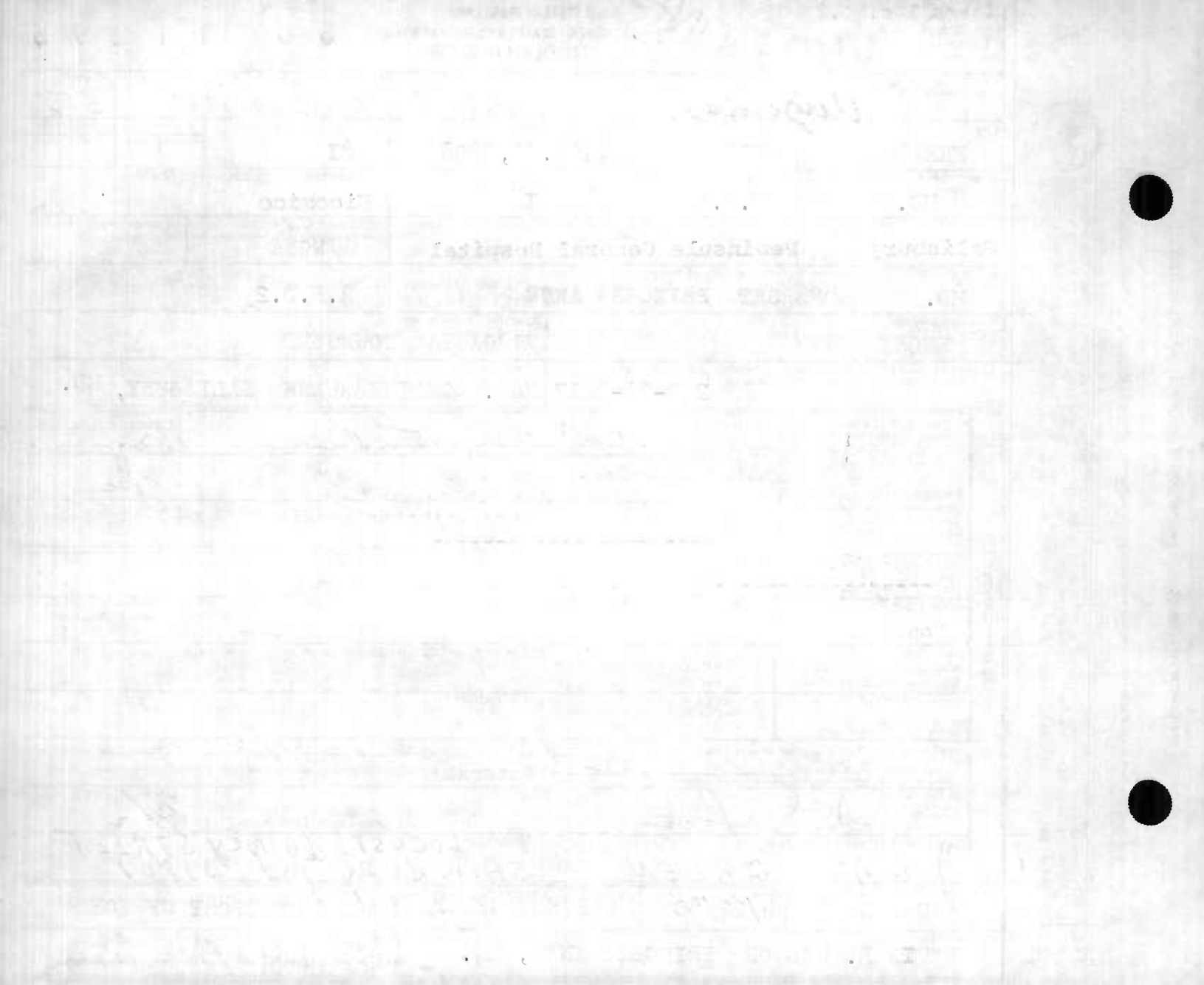
San Francisco

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If Item 21 is marked or Item 18 shows any injury, or other traumatic event, the medical examiner must be notified at ()

FOR 1- STATE REGISTRAR										DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH										REG. NO. 80 11295			
1. DECEASED NAME (TYPE OR PRINT) <i>Virginia</i>				FIRST <i>RIGGIN</i>				LAST <i>RIGGIN</i>				2a. DATE OF DEATH MONTH DAY YEAR <i>APRIL 20, 1980</i>				2b. HOUR <i>5:32</i> A M							
3 SEX <i>FEMALE</i>				4 RACE <i>WHITE</i>				5. DATE OF BIRTH MONTH DAY YEAR <i>AUG. 19, 1898</i>				6. AGE (IN YEARS LAST BIRTHDAY) <i>81</i> YRS				IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS HOURS MIN.							
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <i>MD.</i>				7b. CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i>				8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>				9. BALTIMORE CITY OR COUNTY OF DEATH <i>Wicomico</i> MD											
10. CITY OR TOWN OF DEATH <i>Salisbury</i>				11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <i>Peninsula General Hospital</i>								12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <i>NONE</i>				12b. KIND OF BUSINESS OR INDUSTRY							
USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE <i>MD.</i> 13b. COUNTY <i>SOMERSET</i> 13c. CITY OR TOWN <i>PRINCESS ANNE</i> 13d. INSIDE CITY LIMITS? <input type="checkbox"/> YES <input type="checkbox"/> NO										13e. STREET ADDRESS <i>R.F.D. 2</i>													
14. FATHER'S NAME FIRST MIDDLE LAST <i>EMORY PUSEY</i>					15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <i>VIRGINIA TOWNSEND</i>																		
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)					16b. SOCIAL SECURITY NO. <i>217-36-0897</i>					17. INFORMANT ADDRESS <i>MRS. DOROTHY RUARK SALISBURY, MD.</i>													
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY <i>4254</i> IMMEDIATE CAUSE (a) <i>Cardiovascular Failure</i> DUE TO, OR AS A CONSEQUENCE OF (b) <i>Angiocardiosclerosis</i> DUE TO, OR AS A CONSEQUENCE OF <i>Severe Arteriosclerosis</i> (c) <i>Chronic Coronary Disease</i>														APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <i>Days</i> <i>gone</i>									
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 11a: <i>Chronic Coronary Disease</i>																							
19a. DATE OF OPERATION <i>None</i>				19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>				20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>											
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR <i>19</i>				21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)															
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK				21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)				21f. LOCATION STREET CITY OR TOWN COUNTY STATE <i>LOCUST QUINCY STREET SALISBURY MD. 21801</i>															
22. I certify that (I (this hospital) attended the deceased from <i>4/18</i> 19 <i>80</i> to <i>4/20</i> 19 <i>80</i> , that (I) (we) last saw the deceased alive on <i>4/20</i> 19 <i>80</i> , and that (I) (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death. <i>Natural</i>																							
22b. SIGNATURE <i>J. Gary Green</i>														DEGREE ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>				22c. DATE SIGNED <i>4/2</i>					
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <i>J. GARY GREEN</i>														22e. ADDRESS <i>LOCUST QUINCY STREET SALISBURY MD. 21801</i>									
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <i>BURIAL</i>				23b. DATE <i>4/22/80</i>				23c. NAME OF CEMETERY OR CREMATORY <i>OLIVERT CEMETERY</i>				23d. LOCATION CITY OR TOWN COUNTY STATE <i>NEAR WESTPOST OFFICE</i>											
24. FUNERAL DIRECTOR <i>LEVIN R. WILSON PRINCESS ANNE, MD.</i>														25a. DATE REC'D. BY REGISTRAR <i>APR 24 1980</i>				25b. REGISTRAR'S SIGNATURE <i>Patricia McCreedy</i>					



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 must be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbonpapers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH										8 0 1 1 2 9 6 REG. NO.	
1. FOR STATE REGISTRAR 1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST Anthony J ROTH					2a. DATE OF DEATH MONTH DAY YEAR April 4, 1980					2b. HOUR 4:30 P	
3. SEX M		4. RACE W		5. DATE OF BIRTH MONTH DAY YEAR 1/18/68			6. AGE (IN YEARS LAST BIRTHDAY) 72 YRS.			IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS. HOURS MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) MD.		7b. CITIZEN OF WHAT COUNTRY? USA		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>			9. BALTIMORE CITY OR COUNTY OF DEATH Wicomico MD.				
10. CITY OR TOWN OF DEATH Salisbury		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Deer's Head Center			12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) AIRCRAFT			12b. KIND OF BUSINESS OR INDUSTRY			
13a. STATE MD.		13b. COUNTY WICOMICO		13c. CITY OR TOWN WESTOVER		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS RUMOLT STAR RT 15A			
14. FATHER'S NAME FIRST MIDDLE LAST JOSEPH ROTH					15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST UNK						
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) UNK			16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) 213092872		17. INFORMANT LOUISE ROTH			ADDRESS ABOVE			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Congestive heart failure & Pneumonia 4292 DUE TO, OR AS A CONSEQUENCE OF (b) ASCVD. DUE TO, OR AS A CONSEQUENCE OF (c) cerebrovascular accident.										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a).											
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)						
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)			21f. LOCATION STREET CITY OR TOWN COUNTY STATE					
22a. I certify that (I) (this hospital) attended the deceased from _____, 19_____, to _____, 19_____, that (I) (we) last saw the deceased alive on _____, 19_____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.											
22b. SIGNATURE M. Shrestha					DEGREE ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>			22c. DATE SIGNED			
22d. PHYSICIAN'S NAME (TYPE OR PRINT) M. Shrestha, M.D.					22e. ADDRESS Deer's Head Center, Salisbury, Md. 21801						
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) BURIAL			23b. DATE 4/9/80		23c. NAME OF CEMETERY OR CREMATORY OAK LAWN			23d. LOCATION CITY OR TOWN COUNTY STATE BALTO. MD.			
24. FUNERAL DIRECTOR NAME J.G. CONNELLY					ADDRESS 300 MACE		25a. DATE REC'D. BY REGISTRAR APR 10 1980		25b. REGISTRAR'S SIGNATURE L. H. H. H.		

MEDICAL CERTIFICATION

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TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE FORMS 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

BP
DHMH-17
(VR 115 ME (1))
30M 7/73

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO.

1. FOR
STATE
REGISTRAR

1. DECEASED NAME (TYPE OR PRINT)		FIRST	MIDDLE	LAST	2a. DATE OF DEATH		KNOWN ESTIMATED	<input checked="" type="checkbox"/> MONTH	DAY	YEAR	2b. HOUR
Jason Allen Seehafer					4 20 80						11:56 a
3. SEX	4. RACE	5. DATE OF BIRTH		6. AGE (IN YEARS)	IF UNDER 1 YR.		IF UNDER 24 HRS.		2c. DATE PRONOUNCED DEAD		2d. HOUR
male	white	3/18/1980		0 YRS.	1 2				4 20 80		a
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH					
Salisbury, Md.		USA				Wicomico County MD.					
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		12b. KIND OF BUSINESS OR INDUSTRY			
Salisbury		Peninsula General Hospital				none		none			
13a. STATE				13b. CITY OR TOWN		13d. INSIDE CITY LIMITS?		13e. STREET ADDRESS			
Maryland				Wicomico		Salisbury		YES <input type="checkbox"/> NO <input type="checkbox"/>		Rt. 1, Pocomoke Road	
14. FATHER'S NAME				15. MOTHER'S MAIDEN NAME							
Roger Glenn Seehafer				Mary Katherine Baldwin							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN)				16b. SOCIAL SECURITY NO.		17. INFORMANT (parents)		ADDRESS same as 13			
No						Mr. & Mrs. Roger G. Seehafer					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I DEATH WAS CAUSED BY: Sudden infant death syndrome											APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
IMMEDIATE CAUSE (a) 7980 Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause lost.											
DUE TO, OR AS A CONSEQUENCE OF (b)											
DUE TO, OR AS A CONSEQUENCE OF (c)											
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a).											
19a. DATE OF OPERATION				19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?						20. AUTOPSY?	
										YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH				21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)					
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>				21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE					
22a. I certify that I took charge of the remains described above, held on Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> .											
ACTUAL SIGNATURE <i>Margarita A. Korell</i>				TITLE (SPECIFY) Assistant				DATE SIGNED 4-21-80			
EXAMINER'S NAME (TYPE OR PRINT) Margarita A. Korell, M.D.				ADDRESS 111 Penn Street							
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial				23b. DATE 4/24/80		23c. NAME OF CEMETERY OR CREMATORY Wicomico Memorial Park, Salisbury, Wicomico County, Maryland		23d. LOCATION CITY OR TOWN COUNTY STATE			
24. FUNERAL DIRECTOR NAME HOLLOWAY FUNERAL HOME, Salisbury, Md.				25a. DATE REC'D. BY REGISTRAR APR 21 1980		25b. REGISTRAR'S SIGNATURE <i>W. J. Brady</i>					

2000

1992-1993

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[illegible]

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE										8 0	1 1 2 9 8	
1. FOR STATE REGISTRAR			CERTIFICATE OF DEATH								REG. NO.	
1. DECEASED NAME (TYPE OR PRINT)			FIRST	MIDDLE	LAST	2a. DATE OF DEATH		MONTH	DAY	YEAR	2b. HOUR	
Charles Dale Siegchrist						4 9					5:50 PM	
3. SEX		4. RACE		5. DATE OF BIRTH		6. AGE (IN YEARS LAST BIRTHDAY)		IF UNDER 1 YEAR		IF UNDER 24 HRS		
Male		White		9-3-1915		64 YRS.		MONTHS		DAYS		
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH						
Md.		USil				Wicomico MD						
10. CITY OR TOWN OF DEATH			11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)			12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)			12b. KIND OF BUSINESS OR INDUSTRY			
Salisbury			Peninsula General Hospital			Salesman			Retail			
USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)												
13a. STATE		13b. COUNTY		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS?		13e. STREET ADDRESS				
Md.		Wor.		Ocean City		YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		131 Jamestown Road				
14. FATHER'S NAME						15. MOTHER'S MAIDEN NAME						
Charles Dale Siegchrist, Sr.						Margaret Truux Siegchrist						
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)						16b. SOCIAL SECURITY NO. (IF YES, GIVE YEAR OR DATES)		17. INFORMANT ADDRESS				
Yes						MD 11		Boone Siegchrist Ocean City, Md.				
18. CAUSE OF DEATH (Enter only one cause per line for 1a, 1b, and 1c.)												
PART I. DEATH WAS CAUSED BY:												
IMMEDIATE CAUSE (a) <u>uremia and pneumonia</u>												
586- DUE TO, OR AS A CONSEQUENCE OF												
(b)												
DUE TO, OR AS A CONSEQUENCE OF												
(c)												
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a)												
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY?		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?			
							YES <input type="checkbox"/> NO <input type="checkbox"/>		YES <input type="checkbox"/> NO <input type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 10, PART I OR PART 2)							
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE							
22a. I certify that (I) (this hospital) attended the deceased from <u>7/21</u> 19 <u>80</u> to <u>4/9</u> 19 <u>80</u> , that (I) (we) last saw the deceased alive on <u>4/9</u> 19 <u>80</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.												
22b. SIGNATURE			DEGREE						22c. DATE SIGNED			
<u>M.B. Jones M.P.</u>									4/11/80			
22d. PHYSICIAN'S NAME (TYPE OR PRINT)			22e. ADDRESS									
23a. BURIAL, CREMATION, REMOVAL SPECIFY			23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION CITY OR TOWN COUNTY STATE					
Cremation			4-11-80		Delmarva Crematory		Lwens, Sussex, Delaware					
24. FUNERAL DIRECTOR NAME						ADDRESS		25a. DATE REC'D. BY REGISTRAR				
Ulrich Funeral Home						Berlin, Md., 21811		APR 21 1980				
								25b. REGISTRAR'S SIGNATURE				
								<u>Harvey McCurdy</u>				

1. Name of the plant or animal: *Pinus strobus*
2. Name of the collector: *W. H. Sargent*
3. Date of collection: *1892*
4. Locality: *Massachusetts*
5. Description of the specimen: *Seeds*
6. Number of specimens: *100*
7. Name of the institution: *U.S. National Herbarium*
8. Name of the collector: *W. H. Sargent*
9. Date of collection: *1892*
10. Locality: *Massachusetts*
11. Description of the specimen: *Seeds*
12. Number of specimens: *100*
13. Name of the institution: *U.S. National Herbarium*
14. Name of the collector: *W. H. Sargent*
15. Date of collection: *1892*
16. Locality: *Massachusetts*
17. Description of the specimen: *Seeds*
18. Number of specimens: *100*
19. Name of the institution: *U.S. National Herbarium*
20. Name of the collector: *W. H. Sargent*
21. Date of collection: *1892*
22. Locality: *Massachusetts*
23. Description of the specimen: *Seeds*
24. Number of specimens: *100*
25. Name of the institution: *U.S. National Herbarium*
26. Name of the collector: *W. H. Sargent*
27. Date of collection: *1892*
28. Locality: *Massachusetts*
29. Description of the specimen: *Seeds*
30. Number of specimens: *100*
31. Name of the institution: *U.S. National Herbarium*
32. Name of the collector: *W. H. Sargent*
33. Date of collection: *1892*
34. Locality: *Massachusetts*
35. Description of the specimen: *Seeds*
36. Number of specimens: *100*
37. Name of the institution: *U.S. National Herbarium*
38. Name of the collector: *W. H. Sargent*
39. Date of collection: *1892*
40. Locality: *Massachusetts*
41. Description of the specimen: *Seeds*
42. Number of specimens: *100*
43. Name of the institution: *U.S. National Herbarium*
44. Name of the collector: *W. H. Sargent*
45. Date of collection: *1892*
46. Locality: *Massachusetts*
47. Description of the specimen: *Seeds*
48. Number of specimens: *100*
49. Name of the institution: *U.S. National Herbarium*
50. Name of the collector: *W. H. Sargent*
51. Date of collection: *1892*
52. Locality: *Massachusetts*
53. Description of the specimen: *Seeds*
54. Number of specimens: *100*
55. Name of the institution: *U.S. National Herbarium*
56. Name of the collector: *W. H. Sargent*
57. Date of collection: *1892*
58. Locality: *Massachusetts*
59. Description of the specimen: *Seeds*
60. Number of specimens: *100*
61. Name of the institution: *U.S. National Herbarium*
62. Name of the collector: *W. H. Sargent*
63. Date of collection: *1892*
64. Locality: *Massachusetts*
65. Description of the specimen: *Seeds*
66. Number of specimens: *100*
67. Name of the institution: *U.S. National Herbarium*
68. Name of the collector: *W. H. Sargent*
69. Date of collection: *1892*
70. Locality: *Massachusetts*
71. Description of the specimen: *Seeds*
72. Number of specimens: *100*
73. Name of the institution: *U.S. National Herbarium*
74. Name of the collector: *W. H. Sargent*
75. Date of collection: *1892*
76. Locality: *Massachusetts*
77. Description of the specimen: *Seeds*
78. Number of specimens: *100*
79. Name of the institution: *U.S. National Herbarium*
80. Name of the collector: *W. H. Sargent*
81. Date of collection: *1892*
82. Locality: *Massachusetts*
83. Description of the specimen: *Seeds*
84. Number of specimens: *100*
85. Name of the institution: *U.S. National Herbarium*
86. Name of the collector: *W. H. Sargent*
87. Date of collection: *1892*
88. Locality: *Massachusetts*
89. Description of the specimen: *Seeds*
90. Number of specimens: *100*
91. Name of the institution: *U.S. National Herbarium*
92. Name of the collector: *W. H. Sargent*
93. Date of collection: *1892*
94. Locality: *Massachusetts*
95. Description of the specimen: *Seeds*
96. Number of specimens: *100*
97. Name of the institution: *U.S. National Herbarium*
98. Name of the collector: *W. H. Sargent*
99. Date of collection: *1892*
100. Locality: *Massachusetts*

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 must be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.35
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MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE										8 0 1 1 2 9 9	
1. FOR STATE REGISTRAR										REG. NO.	
1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST Milton W. SKIPPER						2a. DATE OF DEATH MONTH DAY YEAR April 27, 1980			2b. HOUR 1:45a M		
3. SEX Male		4. RACE White		5. DATE OF BIRTH MONTH DAY YEAR 4 4 01		6. AGE (IN YEARS LAST BIRTHDAY) 79 YRS.		7. IF UNDER 1 YEAR MONTHS DAYS		7. IF UNDER 24 HRS. HOURS MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Maryland		7b. CITIZEN OF WHAT COUNTRY? USA		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Wicomico MD.					
10. CITY OR TOWN OF DEATH Salisbury		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Deer's Head Center				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Plumbing			12b. KIND OF BUSINESS OR INDUSTRY Retired		
USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)						13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>					
13a. STATE Maryland		13b. COUNTY Wicomico		13c. CITY OR TOWN Salisbury		13e. STREET ADDRESS 623 Liberty Street					
14. FATHER'S NAME FIRST MIDDLE LAST Andrew J. Skipper				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Emma A.				ADDRESS 304 Kenwood Avenue			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No				16b. SOCIAL SECURITY NO. 212-01-6105A		17. INFORMANT Mrs Margaret Coleman Baltimore, Md. 21228					
18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Senile Degeneration</u> 4292 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last (b) _____ (c) _____ DUE TO, OR AS A CONSEQUENCE OF DUE TO, OR AS A CONSEQUENCE OF										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a): A S C V D											
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)					
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)			21f. LOCATION STREET CITY OR TOWN COUNTY STATE					
22a. I certify that (I) (this hospital) attended the deceased from _____, 19_____, to _____, 19_____, that (I) (we) lost saw the deceased alive on _____, 19_____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.											
22b. SIGNATURE E. P. Ritchings, M.D.						DEGREE ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/>			22c. DATE SIGNED 4/27/80		
22d. PHYSICIAN'S NAME (TYPE OR PRINT) E. P. RITCHINGS, M. D.						22e. ADDRESS Deer's Head Center, Salisbury, Md. 21801					
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial			23b. DATE 4/29/80		23c. NAME OF CEMETERY OR CREMATORY Lorraine Park			23d. LOCATION CITY OR TOWN COUNTY STATE Woodlawn Balto Md			
24. FUNERAL DIRECTOR NAME Witzke Funeral Home of Catonsville 1630 Edmondson Avenue Catonsville, Md. 21228						25a. DATE REC'D. BY REGISTRAR APR 29 1980			25b. REGISTRAR'S SIGNATURE L. H. H. H.		

END C.F.

1-1-3

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH										8011300									
1. FOR STATE REGISTRAR		2a. DATE OF DEATH				MONTH		DAY		YEAR		2b. HOUR							
1. DECEASED NAME (TYPE OR PRINT)		FIRST		MIDDLE		LAST		2a. DATE OF DEATH		MONTH		DAY		YEAR		2b. HOUR			
Victoria		Stennett						April		18		1980		10p.m.					
3 SEX		4 RACE		5. DATE OF BIRTH		MONTH		DAY		YEAR		6 AGE (IN YEARS LAST BIRTHDAY)		7 YRS.		8 IF UNDER 1 YEAR		9 IF UNDER 24 HRS	
Female		White		Feb. 21, 1905								75							
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)		7b. CITIZEN OF WHAT COUNTRY?		8 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>		WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9 BALTIMORE CITY OR COUNTY OF DEATH											
Richmond, Va.		USA						Wicomico											
10 CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		12b. KIND OF BUSINESS OR INDUSTRY													
Salisbury		Peninsula General Hospital		Housewife		none													
13a. STATE		13b. COUNTY		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS?		13e. STREET ADDRESS											
Maryland		Wicomico		Salisbury		YES <input type="checkbox"/> NO <input type="checkbox"/>		1323 Glenn Ave.											
14 FATHER'S NAME		15 MOTHER'S MAIDEN NAME																	
William		Patterson		Southall		Annie		Graves											
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)		16b. SOCIAL SECURITY NO.		17 INFORMANT (son)		ADDRESS													
NO		230-26-9530		Mr. Richard D. Stennett, Alexandria, Va.															
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH									
PART I. DEATH WAS CAUSED BY																			
IMMEDIATE CAUSE (a) <i>Ventricular Fibrillation</i>																			
410- DUE TO, OR AS A CONSEQUENCE OF																			
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.																			
(b) <i>Acute Anteroseptal M.I.</i>																			
DUE TO, OR AS A CONSEQUENCE OF																			
(c) <i>Ischemic Cardiovascular disease</i>																			
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)																			
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY?		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?											
						YES <input type="checkbox"/> NO <input type="checkbox"/>		YES <input type="checkbox"/> NO <input type="checkbox"/>											
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)															
		HOUR A.M. MONTH DAY YEAR																	
		P.M. 19																	
21d. INJURY OCCURRED		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION		CITY OR TOWN		COUNTY		STATE									
WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>																			
22a. I certify that (I) (this hospital) attended the deceased from <i>4/18</i> 19 <i>80</i> , to <i>4/18</i> 19 <i>80</i> , that (I) (we) lost saw the deceased alive on <i>4/18</i> 19 <i>80</i> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.																			
22b. SIGNATURE										DEGREE		22c. DATE SIGNED							
<i>Clayton L. Raab M.D.</i>																			
22d. PHYSICIAN'S NAME (TYPE OR PRINT)										22e. ADDRESS									
<i>Clayton L. Raab M.D.</i>										<i>Focus & Quincy Sts Salisbury Md</i>		<i>2/80</i>							
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION		CITY OR TOWN		COUNTY		STATE							
Burial		4/22/80		Oakwood Cemetery		Richmond		Henrico		Virginia									
24 FUNERAL DIRECTOR										25a. DATE RECEIVED BY REGISTRAR		25b. REGISTRAR'S SIGNATURE							
HOLLOWAY FUNERAL HOME, Salisbury, Md.										APR 22 1980		<i>John H. Holloway</i>							

W. J. ...
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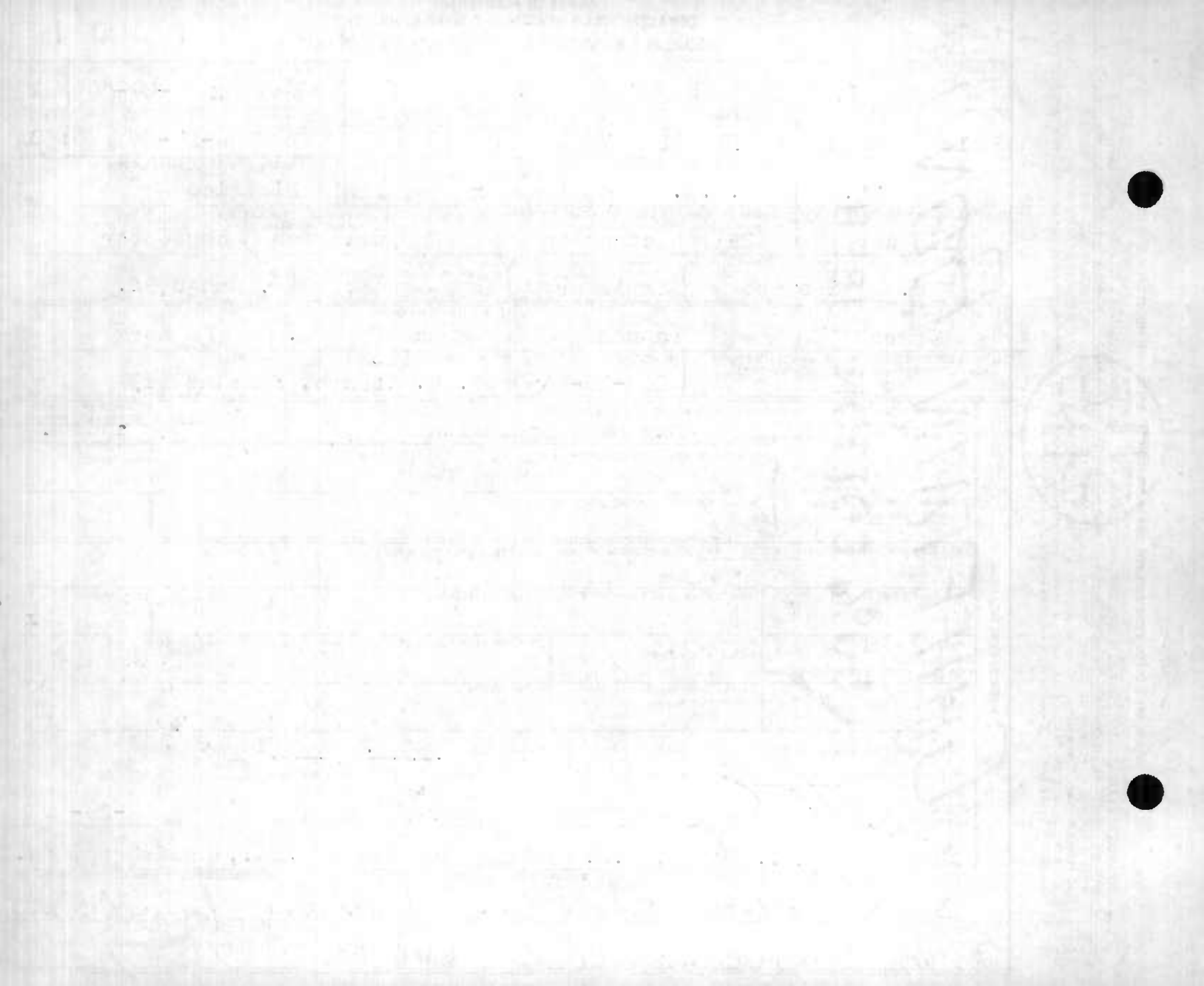
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TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH, IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL-TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED, WITHIN 24 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

FOR 1- STATE REGISTRAR												DEPARTMENT OF HEALTH AND MENTAL HYGIENE MEDICAL EXAMINER'S CERTIFICATE OF DEATH												REG. NO. 11301									
1. DECEASED NAME (TYPE OR PRINT)												FIRST MIDDLE LAST												2a. DATE KNOWN OF DEATH				MONTH DAY YEAR				2b. HOUR	
LAUREL JAMES TAPMAN																								4-29-80				A M					
3. SEX		4. RACE		5. DATE OF BIRTH		6. AGE (IN YEARS)		IF UNDER 1 YR.		IF UNDER 24 HRS.		7c. DATE PRONOUNCED DEAD		MONTH DAY YEAR		2d. HOUR																	
Male		White		4 21 02		78 YRS.						4-29-80		19 8:50		A M																	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)				7b. CITIZEN OF WHAT COUNTRY?				8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>				9. BALTIMORE CITY OR COUNTY OF DEATH																					
Va.				U.S.A.								Wicomico																					
10. CITY OR TOWN OF DEATH				11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)				12b. KIND OF BUSINESS OR INDUSTRY																					
Salisbury				221 Chestnut Way				waterman & carpenter																									
USUAL RESIDENCE (IF IN NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)												13d. INSIDE CITY LIMITS?				13e. STREET ADDRESS																	
13a. STATE 13b. COUNTY 13c. CITY OR TOWN												YES <input type="checkbox"/> NO <input type="checkbox"/>				Box 231, Wango Rd.																	
14. FATHER'S NAME												15. MOTHER'S MAIDEN NAME																					
FIRST MIDDLE LAST												FIRST MIDDLE LAST																					
James Tapman												Emma S. Shaw																					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN)				16b. SOCIAL SECURITY NO.				17. INFORMANT (son)				ADDRESS																					
No				220-10-9550				Wm. C. Tapman, Same as #13																									
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)																APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH																	
PART I DEATH WAS CAUSED BY:																sudden																	
IMMEDIATE CAUSE (a) Coronary Occlusion																																	
410- Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause lost.																																	
DUE TO, OR AS A CONSEQUENCE OF																																	
(b) DUE TO, OR AS A CONSEQUENCE OF																																	
(c)																																	
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a).																																	
19a. DATE OF OPERATION				19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?												20. AUTOPSY?																	
																YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>																	
21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH				21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR				21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)																									
				P.M. 19																													
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK				21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)				21f. LOCATION																									
								CITY OR TOWN COUNTY STATE																									
22a. I certify that I took charge of the remains described above, held on death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion																																	
TITLE (SPECIFY) M.D. Deputy MEDICAL EXAMINER DATE SIGNED 4-29-80																																	
ACTUAL SIGNATURE																																	
EXAMINER'S NAME (TYPE OR PRINT) Earl L. Royer, M.D. ADDRESS 409 Camden Ave., Salisbury, Md.																																	
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)				23b. DATE				23c. NAME OF CEMETERY OR CREMATORY				23d. LOCATION																					
Burial				5-1-80				Knight Ave				Messers, Annapolis Co. R																					
24. FUNERAL DIRECTOR NAME ADDRESS																25a. DATE REC'D. BY REGISTRAR				25b. REGISTRAR'S SIGNATURE													
MAY 6 1980																																	

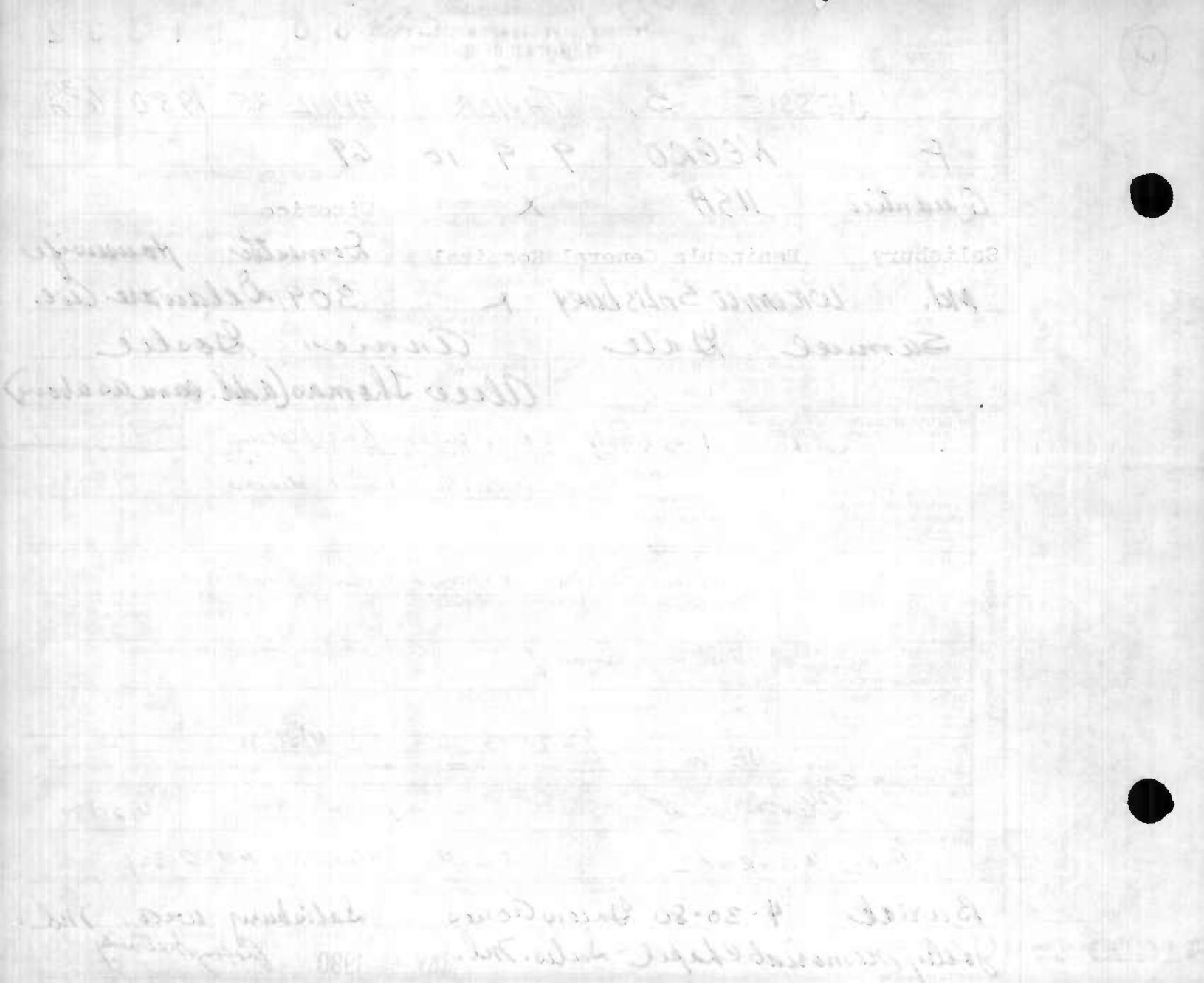


TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If Item 21 is marked or Item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE										8011302	
1. FOR STATE REGISTRAR					REG. NO.						
1. DECEASED NAME (TYPE OR PRINT) JESSIE B. TAYLOR					2a. DATE OF DEATH APRIL 25 1980			2b. HOUR 6 ³⁰ A.M.			
3. SEX F		4. RACE NEGRO		5. DATE OF BIRTH 9 9 10		6. AGE (IN YEARS LAST BIRTHDAY) 69 YRS		7. IF UNDER 1 YEAR MONTHS DAYS		7b. IF UNDER 24 HRS HOURS MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Quintana Roo		7b. CITIZEN OF WHAT COUNTRY? USA		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Wicomico MD.					
10. CITY OR TOWN OF DEATH Salisbury		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Peninsula General Hospital				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Domestic		12b. KIND OF BUSINESS OR INDUSTRY Housewife			
13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE Md.				13b. COUNTY Wicomico		13c. CITY OR TOWN Salisbury		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS 309 Delaware Ave.	
14. FATHER'S NAME FIRST MIDDLE LAST Samuel Gale				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Annie Goslee							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)				16b. SOCIAL SECURITY NO.		17. INFORMANT ADDRESS Alice Thomas (add. same as above)					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Probable ventricular fibrillation 4140 DUE TO, OR AS A CONSEQUENCE OF (b) Atherosclerotic heart disease DUE TO, OR AS A CONSEQUENCE OF (c) APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH few minutes years											
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a) Diabetes - Osteoarthritis - organic Brain Syndrome											
19a. DATE OF OPERATION				19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)					
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>				21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE					
22a. I certify that (I) (this hospital) attended the deceased from 12-10-73, 19 to 4/21/80, 19 that (I) (we) lost saw the deceased alive on 4/21/80, 19 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (do) (did not) view the body after death.											
22b. SIGNATURE [Signature]				DEGREE ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>				22c. DATE SIGNED 4/25/80			
22d. PHYSICIAN'S NAME (TYPE OR PRINT) BAL AGARWAL				22e. ADDRESS P.G.H. Salisbury Md 21801.							
23a. BURIAL, CREMATION, REMOVAL (SEE IF) Burial				23b. DATE 4-30-80		23c. NAME OF CEMETERY OR CREMATORY Green Acres		23d. LOCATION CITY OR TOWN COUNTY STATE Salisbury Wicomico Md.			
24. FUNERAL DIRECTOR Jolly Memorial Chapel - Salis. Md.				25a. DATE REC'D. BY REGISTRAR MAY 2 1980				25b. REGISTRAR'S SIGNATURE [Signature]			



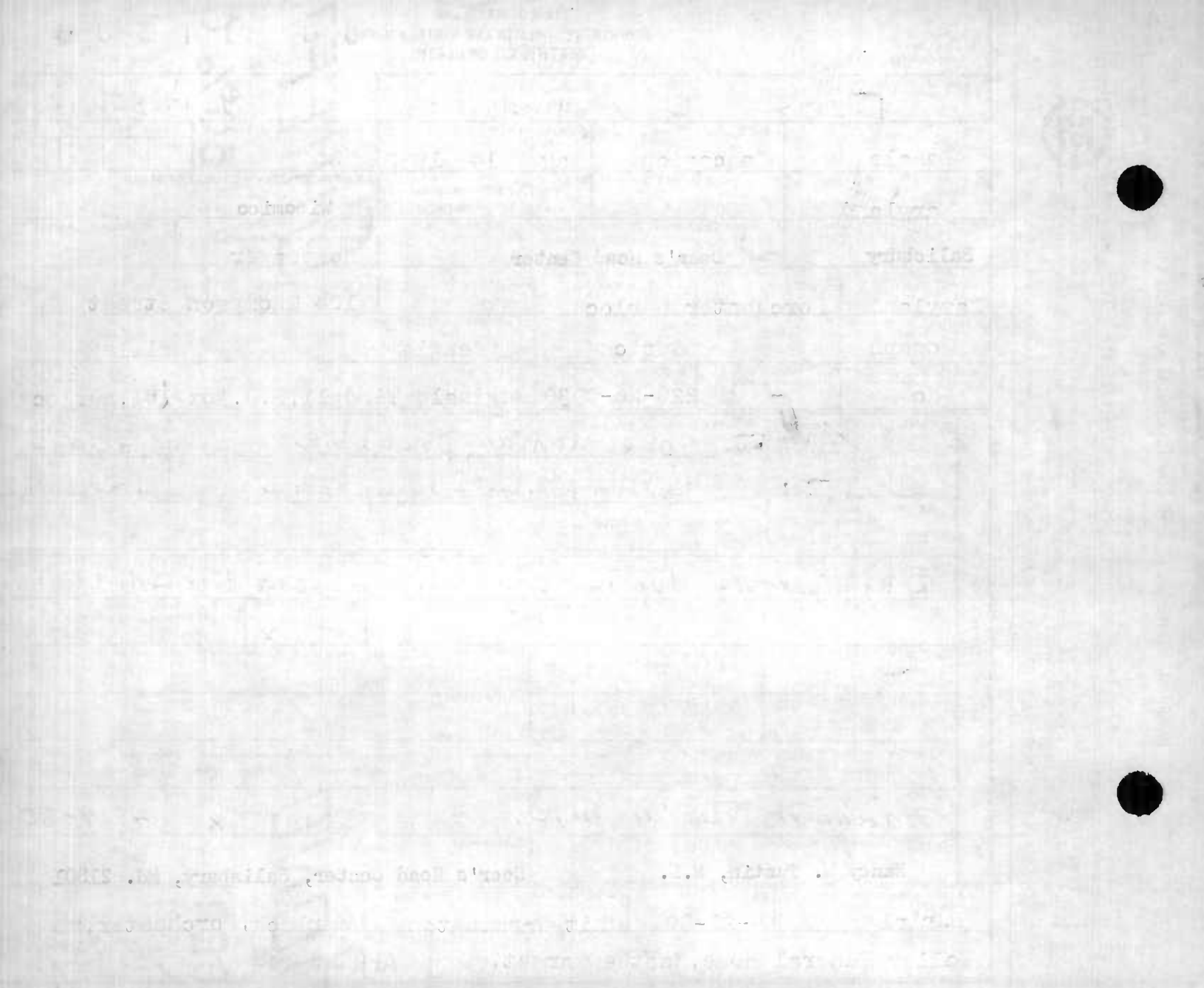
TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 must be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH										REG. NO. 70 11303	
1. FOR STATE REGISTRAR			1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST Doris C Tindall				2a. DATE OF DEATH MONTH DAY YEAR 4 19 80		2b. HOUR 6:30am		
3. SEX Female		4. RACE Caucasian		5. DATE OF BIRTH MONTH DAY YEAR May 14 1930		6. AGE (IN YEARS LAST BIRTHDAY) 49 YRS.		7. IF UNDER 1 YEAR MONTHS DAYS		7b. IF UNDER 24 HRS. HOURS MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Maryland		7b. CITIZEN OF WHAT COUNTRY? USA		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Wi comi co MD					
10. CITY OR TOWN OF DEATH Salisbury		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Deer's Head Center				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Homemaker		12b. KIND OF BUSINESS OR INDUSTRY			
13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) STATE Maryland			13b. COUNTY Dorchester		13c. CITY OR TOWN Hurlock		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS 104 Thompson Street		
14. FATHER'S NAME FIRST MIDDLE LAST Joseph Gusick				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Jennie Willey							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No			16b. SOCIAL SECURITY NO. 220-26-0930		17. INFORMANT Reginald Tindall		ADDRESS P.O. Box 141, Hurlock		MD 21643		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>pneumonia, probable</u> DUE TO, OR AS A CONSEQUENCE OF (b) <u>brain tumor - lymphoma</u> DUE TO, OR AS A CONSEQUENCE OF (c) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 3 days 18 months	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (b): <u>(R) hemiparesis due to craniotomy, congestive heart failure</u>											
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)						
21d. INJURY OCCURRED WHERE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE						
22a. I certify that (I) (this hospital) attended the deceased from _____, 19_____, to _____, 19_____, that (I) (we) lost saw the deceased alive on _____, 19_____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.											
22b. SIGNATURE Nancy W. Tustin, M.D.						DEGREE ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/>		22c. DATE SIGNED 4-19-80			
22d. PHYSICIAN'S NAME (TYPE OR PRINT) Nancy W. Tustin, M.D.						22e. ADDRESS Deer's Head Center, Salisbury, Md. 21801					
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial			23b. DATE 4-21-80		23c. NAME OF CEMETERY OR CREMATORY Unity Washington		23d. LOCATION CITY OR TOWN COUNTY STATE Hurlock, Dorchester, MD				
24. FUNERAL DIRECTOR NAME Zeller Funeral Home, East New Market, MD						25a. DATE REC'D. BY REGISTRAR APR 23 1980		25b. REGISTRAR'S SIGNATURE [Signature]			

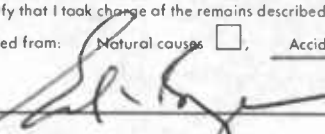
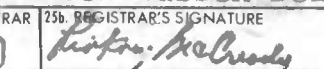
MEDICAL CERTIFICATION



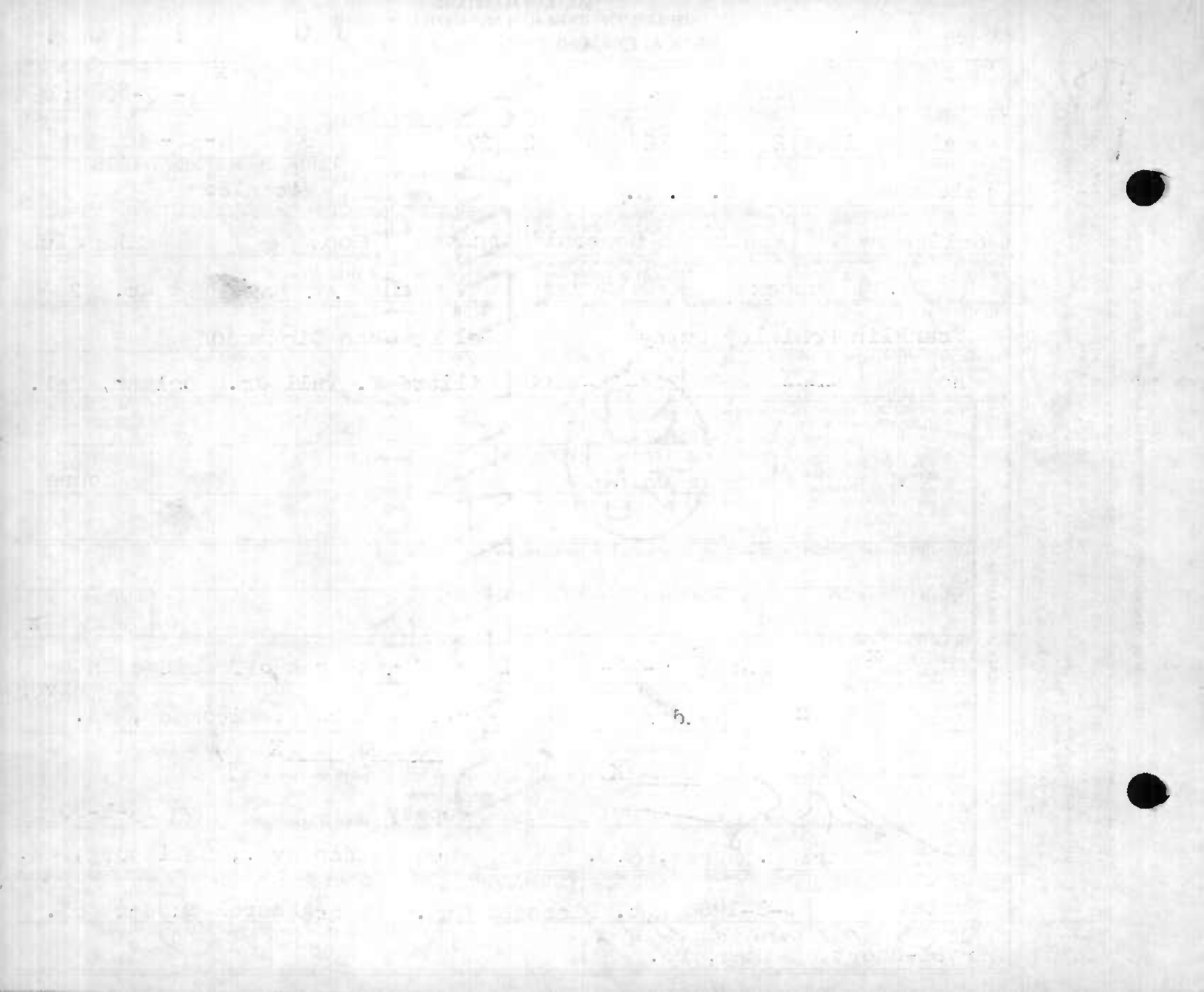
BP

DHMM - 17
(VR A15 ME (1))
30M 7/73

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. GIVE PAGE 4 TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 5 FOR YOUR OFFICE. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL-TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED, WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

FOR 1- STATE REGISTRAR										DEPARTMENT OF HEALTH AND MENTAL HYGIENE MEDICAL EXAMINER'S CERTIFICATE OF DEATH										REG. NO. 11304	
1. DECEASED NAME (TYPE OR PRINT) BEATRICE G. TULL						2a. DATE KNOWN OF DEATH MONTH DAY YEAR 4-30-80 8 15A						2b. HOUR									
3. SEX Female		4. RACE White		5. DATE OF BIRTH MONTH DAY YEAR 2 3 32		6. AGE (IN YEARS) (LAST BIRTHDAY) 48 YRS.		IF UNDER 1 YR. MONTHS DAYS 2 27		IF UNDER 24 HRS. HOURS MIN.		2c. DATE PRONOUNCED DEAD MONTH DAY YEAR 4-30-80 19		2d. HOUR 11 M							
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Delaware				7b. CITIZEN OF WHAT COUNTRY? U. S. A.				8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>				9. BALTIMORE CITY OR COUNTY OF DEATH Wicomico MD.									
10. CITY OR TOWN OF DEATH Salisbury				11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Peninsula General Hospital				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Cook				12b. KIND OF BUSINESS OR INDUSTRY Elks Club									
13a. STATE De.				13b. COUNTY Sussex		13c. CITY OR TOWN Delmar		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET ADDRESS P.O. Box 146 Rt. #2											
14. FATHER'S NAME FIRST MIDDLE LAST Franklin McKinley Pusey						15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Delema Jane Dickerson															
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) no				16b. SOCIAL SECURITY NO. -----		17. INFORMANT Willard T. Tull Jr.				ADDRESS Delmar, Del.											
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1 DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Asphyxia</u> 8160 Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last. (b) <u>Drowning</u> (c) _____ DUE TO, OR AS A CONSEQUENCE OF DUE TO, OR AS A CONSEQUENCE OF												APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH hours									
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a).																					
19a. DATE OF OPERATION				19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?								20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>									
21a. EXTERNAL CAUSE WAS UNDERLYING <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH				21b. TIME OF INJURY HOUR AM MONTH DAY YEAR 6:53 PM 4-29-80				21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2) Driver of auto ran off bridge into river.													
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input checked="" type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input checked="" type="checkbox"/>				21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.) bridge				21f. LOCATION STREET CITY OR TOWN COUNTY STATE City Park, Salisbury, Wicomico, Md.													
22a. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and in my opinion death resulted from: Natural causes <input type="checkbox"/> , Accident <input checked="" type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/> .																					
ACTUAL SIGNATURE 				TITLE (SPECIFY) Deputy				M.D. MEDICAL EXAMINER				DATE SIGNED 5-1-80									
EXAMINER'S NAME (TYPE OR PRINT) Earl L. Royer, M.D.				ADDRESS 409 Camden Ave., Salisbury, Md.																	
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial				23b. DATE 5-3-1980		23c. NAME OF CEMETERY OR CREMATORY Mt. Pleasant Cem.				23d. LOCATION CITY OR TOWN COUNTY STATE Near Laurel Sussex Del.											
24. FUNERAL DIRECTOR NAME William M. Short Jr. ADDRESS Marvel-Short, Delmar, De.				25a. DATE REC'D. BY REGISTRAR MAY 5 1980				25b. REGISTRAR'S SIGNATURE 													

MEDICAL CERTIFICATION



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

FOR
STATE
REGISTRARSTATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST Lillian Conway Turner			2a. DATE OF DEATH MONTH DAY YEAR April 9 1980		2b. HOUR 4 P.M.
3. SEX Female	4. RACE AA	5. DATE OF BIRTH MONTH DAY YEAR 8-7-1904	6. AGE (IN YEARS LAST BIRTHDAY) 75 YRS	# UNDER 1 YEAR MONTHS DAYS	# UNDER 24 HRS HOURS MIN.
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Del	7b. CITIZEN OF WHAT COUNTRY? U.S.	8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	9. BALTIMORE CITY OR COUNTY OF DEATH Wicomico MD.		
10. CITY OR TOWN OF DEATH Salisbury	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Peninsula General Hospital		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Unemployed		12b. KIND OF BUSINESS OR INDUSTRY —
13a. STATE Md	13b. COUNTY Wicomico	13c. CITY OR TOWN Jessville	13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	13. STREET ADDRESS Texas Bt.	
14. FATHER'S NAME FIRST MIDDLE LAST Benjamin Dashiell		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Laura Cook			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No		16b. SOCIAL SECURITY NO. 222-05-2778		17. INFORMANT ADDRESS	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY. IMMEDIATE CAUSE (a) Cardiogenic Shock 4292 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost (b) Myocardial Infarction (c) Congestive Heart Failure					APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)					
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>	20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)	
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE	
22. I certify that (I) (this hospital) attended the deceased from 4/9/80 to 4/9/80 , that (I) (we) lost saw the deceased alive on 4/9/80 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.					
22b. SIGNATURE Helen M. Baldado		DEGREE M.D.		22c. DATE SIGNED 4/9/80	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) Helen M Baldado		22e. ADDRESS 237 Florida Ave. Salisbury Maryland			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial	23b. DATE 4/12/80	23c. NAME OF CEMETERY OR CREMATORY Elsey Cem.		23d. LOCATION CITY OR TOWN Jessville Md	
24. FUNERAL DIRECTOR NAME C. W. Yessie, Jr.		ADDRESS Bvline, Md		25a. DATE REC'D. BY REGISTRAR APR 11 1980	

General 4/12/80 Easy Com.
W. J. French, 4/12/80
Jester's, Mt.

176 — 222-02-2218
Bongamin Dasthrell
X Morris Jester's
X Texas 84
Cook

Del
V. 2
8-7-1904
X

Benjamin General Hospital
Vanderbilt

Form 10
AA
Lillian County
75

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death and may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours of the death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

MEDICAL CERTIFICATION

1- FOR STATE REGISTRAR				STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH				REG. NO. 8011306			
1 DECEASED NAME (TYPE OR PRINT) Anna May Upright				2a DATE OF DEATH MONTH DAY YEAR April 8 80				2b HOUR 2:30 P M			
3 SEX Female		4 RACE White		5 DATE OF BIRTH MONTH DAY YEAR 12 17 05		6 AGE (IN YEARS LAST BIRTHDAY) 74 YRS.		7 UNDER 1 YEAR MONTHS DAYS		7 UNDER 24 HRS HOURS MIN	
7a BIRTHPLACE (STATE OR FOREIGN COUNTRY) Delaware		7b CITIZEN OF WHAT COUNTRY? U.S.A.		8 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9 BALTIMORE CITY OR COUNTY OF DEATH Wicomico MD.					
10 CITY OR TOWN OF DEATH Salisbury		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Peninsula General Hospital				12a USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Post-Master		12b KIND OF BUSINESS OR INDUSTRY Government			
13a STATE Del.		13b COUNTY Sussex		13c CITY OR TOWN Millsboro		13d INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>		13e STREET ADDRESS 324 Deck Street			
14 FATHER'S NAME FIRST MIDDLE LAST Clarence C. Norris				15 MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Mabel P. Dilworth							
16a WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No		16b SOCIAL SECURITY NO. 222-14-9364		17 INFORMANT ADDRESS Mrs. Jane E. Kipp Millsboro, Del. 402 Shroud St.							
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>COLD & CVA</u> <u>496-</u> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) _____											
19a DATE OF OPERATION		19b CONDITION FOR WHICH OPERATION WAS PERFORMED				20a AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>			
21a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)							
21d INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f LOCATION STREET CITY OR TOWN COUNTY STATE							
22a I certify that (I) (this hospital) attended the deceased from <u>4/8</u> <u>3/4</u> 19 <u>80</u> , to <u>4/8</u> 19 <u>80</u> , that (I) (we) lost saw the deceased alive on <u>4/8</u> 19 <u>80</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.											
22b SIGNATURE M Ben Horner MD				DEGREE MD				22c DATE SIGNED 4/8/80			
22d PHYSICIAN'S NAME (TYPE OR PRINT) W BEN HORNER				22e ADDRESS MAY AVE SALISBURY MD 21801							
23a BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b DATE 4/11/80		23c NAME OF CEMETERY OR CREMATORY Longwood Cemetery		23d LOCATION CITY OR TOWN COUNTY STATE Kennett Sq. Chester, Pa.					
24 FUNERAL DIRECTOR NAME Holloway Funeral Home P.A. Salisbury, Md.				25a DATE REC'D. BY REGISTRAR APR 11 1980		25b REGISTRAR'S SIGNATURE [Signature]					

Upright

Peninsula General Hospital

Calicut

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE										8 0 1 1 3 0 7	
1 - FOR STATE REGISTRAR										CERTIFICATE OF DEATH	
1 DECEASED NAME (TYPE OR PRINT)										2a. DATE OF DEATH	
FIRST MIDDLE LAST										MONTH DAY YEAR	
2b. HOUR											
3 SEX										4 RACE	
5. DATE OF BIRTH										6. AGE (IN YEARS LAST BIRTHDAY)	
MONTH DAY YEAR										IF UNDER 1 YEAR	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)										7b. CITIZEN OF WHAT COUNTRY?	
8 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>										9 BALTIMORE CITY OR COUNTY OF DEATH	
10 CITY OR TOWN OF DEATH										11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)	
12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)										12b. KIND OF BUSINESS OR INDUSTRY	
13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)										13b. INSIDE CITY LIMITS?	
13c. STREET ADDRESS										13d. INSIDE CITY LIMITS?	
14 FATHER'S NAME										15 MOTHER'S MAIDEN NAME	
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)										16b. SOCIAL SECURITY NO	
17 INFORMANT										ADDRESS	
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY:										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
IMMEDIATE CAUSE (a)											
DUE TO, OR AS A CONSEQUENCE OF											
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last											
DUE TO, OR AS A CONSEQUENCE OF											
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1											
19a. DATE OF OPERATION										19b. CONDITION FOR WHICH OPERATION WAS PERFORMED	
20a. AUTOPSY?										20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)										21b. TIME OF INJURY	
21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)											
21d. INJURY OCCURRED										21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)	
21f. LOCATION											
22a. I certify that (I) (this hospital) attended the deceased from										22b. DATE SIGNED	
22c. SIGNATURE											
22d. PHYSICIAN'S NAME (TYPE OR PRINT)										22e. ADDRESS	
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)										23b. DATE	
23c. NAME OF CEMETERY OR CREMATORY										23d. LOCATION	
23e. DATE REC'D BY REGISTRAR										23f. REGISTRAR'S SIGNATURE	

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

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DHMH-16 25M
(VRA 15, 4) 1/79

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

8 0 1 1 3 0 8

FOR
STATE
REGISTRAR

REG. NO.

1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST CHARLES H. WATSON, JR.			2a. DATE OF DEATH MONTH DAY YEAR APRIL 2, 1980			2b. HOUR P 4:00 P				
3 SEX MALE		4 RACE WHITE		5 DATE OF BIRTH MONTH DAY YEAR JULY 23, 1902		6 AGE (IN YEARS LAST BIRTHDAY) YRS 77		7. IF UNDER 1 YEAR MONTHS DAYS 77		
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) MARYLAND		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Wicomico MD.				
10 CITY OR TOWN OF DEATH Salisbury		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Peninsula General Hospital				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Pres. Ret. Wholesale Beer		12b. KIND OF BUSINESS OR INDUSTRY		
13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13b. STATE 13c. COUNTY Maryland Wicomico			13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS 201 TRUITT ST					
14. FATHER'S NAME FIRST MIDDLE LAST Cornelius Watson			15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST OLLIE Unknown			16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No			16b. SOCIAL SECURITY NO (IF YES, GIVE WAR OR DATES) 900-02-9096	
17. INFORMANT NAME ADDRESS Charles J. Potts, 045 PLAZA EAST Salisbury Md.										
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Hepatic Coma 5722 DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____									APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a) Chronic Alcoholism										
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)				
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)			21f. LOCATION STREET CITY OR TOWN COUNTY STATE				
22. I certify that (I) (this hospital) attended the deceased from 3/29 , 19 80 , to 4/2 , 19 80 , that (I) (we) last saw the deceased alive on 4/2 , 19 80 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.										
22b. SIGNATURE Benito Chan			DEGREE MD			ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>			22c. DATE SIGNED 4/2/80	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) BENITO CHAN			22e. ADDRESS 547 D. Riverside Rd Salisbury Maryland 21801							
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial			23b. DATE 4-4-1980		23c. NAME OF CEMETERY OR CREMATORY Parsons Cem.		23d. LOCATION CITY OR TOWN COUNTY STATE Salisbury MD			
24. FUNERAL DIRECTOR NAME ADDRESS Hill-Baker-Bounds Salisbury Md.			25a. DATE REC'D. BY REGISTRAR APR 7 1980		25b. REGISTRAR'S SIGNATURE Hilary McBrady					

BP



Director

General Hospital

Sanitary

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH									
1. FOR STATE REGISTRAR		8 0 1 1 3 0 9				REG. NO.			
1. DECEASED NAME (TYPE OR PRINT) <u>Levin Raymond. WATSON</u>					2a. DATE OF DEATH MONTH DAY YEAR <u>APRIL 29 1980</u>			2b. HOUR <u>8²⁸</u> A. M.	
3. SEX <u>Male</u>		4. RACE <u>Caucasian</u>		5. DATE OF BIRTH MONTH DAY YEAR <u>Mar. 25 1904</u>		6. AGE (IN YEARS LAST BIRTHDAY) <u>76</u> YRS.		7. IF UNDER 1 YEAR MONTHS DAYS HOURS MIN.	
2a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <u>Md.</u>		7b. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <u>Wicomico</u> MD.			
10. CITY OR TOWN OF DEATH <u>Salisbury</u>		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <u>Peninsula General Hospital</u>				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <u>Poultry Farmer</u>		12b. KIND OF BUSINESS OR INDUSTRY <u>Broiler Prods.</u>	
13a. STATE <u>Md.</u>		13b. COUNTY <u>Worcester</u>		13c. CITY OR TOWN <u>Berlin</u>		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET ADDRESS <u>Rt. 4, Box 460</u>	
14. FATHER'S NAME FIRST MIDDLE LAST <u>William - Watson</u>		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <u>Grace - White</u>							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <u>No</u>		16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) <u>218-16-7715-A</u>		17. INFORMANT ADDRESS <u>Martha J. Watson Rt. 4, Box 460 Berlin Md.</u>					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Myocardial Infarction, Most Probable</u> DUE TO, OR AS A CONSEQUENCE OF (b) <u>due to coronary artery</u> DUE TO, OR AS A CONSEQUENCE OF (c) <u>chronic obstructive Pulmonary disease</u>									
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) <u>chronic obstructive Pulmonary disease</u>									
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)					
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE					
22a. I certify that (I) (this hospital) attended the deceased from <u>4/17</u> 19 <u>80</u> , to <u>4/29</u> 19 <u>80</u> , that (I) (we) last saw the deceased alive on <u>4/29</u> 19 <u>80</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.									
22b. SIGNATURE <u>J. Smith</u>				DEGREE <u>M.D.</u>		ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <u>JOSEPH Z. BADROS</u>				22e. ADDRESS <u>229 FLORIDIA AVE SALISBURY Md. 21801</u>					
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>Burial</u>		23b. DATE <u>5/3/80</u>		23c. NAME OF CEMETERY OR CREMATORY <u>Lewis Cemetery</u>		23d. LOCATION CITY OR TOWN COUNTY STATE <u>Willards Wicomico Md.</u>			
24. FUNERAL DIRECTOR NAME <u>Anna A. Burkley</u>		ADDRESS <u>108 Williams St. Berlin Md.</u>		25a. DATE FILED BY REGISTRAR <u>1980</u>		25b. REGISTRAR'S SIGNATURE <u>John McCreedy</u>			

David

08/01/01

Lewis (Carter)

2154/11W

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TO HOSPITALS: ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbonpapers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

FOR
STATE
REGISTRAR

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

1 DECEASED NAME (TYPE OR PRINT) Helen FISHER West			2a DATE OF DEATH MONTH DAY YEAR 4-10-80			2b HOUR 11:20P M			
3 SEX F		4 RACE W		5 DATE OF BIRTH MONTH DAY YEAR 11-4-91		6 AGE (IN YEARS LAST BIRTHDAY) 88 YRS.		7 IF UNDER 1 YEAR MONTHS DAYS HOURS MIN	
7a BIRTHPLACE (STATE OR FOREIGN COUNTRY) DE		7b CITIZEN OF WHAT COUNTRY? U.S.		8 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9 BALTIMORE CITY OR COUNTY OF DEATH Wicomico County MD.			
10 CITY OR TOWN OF DEATH Salisbury		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Salisbury Nursing Home				12a USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) RET TEACHER		12b KIND OF BUSINESS OR INDUSTRY EDUCATION	
13a STATE DELA			13b COUNTY SUSS		13c CITY OR TOWN GROGETOWN		13d INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		
14 FATHER'S NAME FIRST MIDDLE LAST PETER CAUSEY SHORT			15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST SARAH CATHERINE HITCHENS			13e STREET ADDRESS 239 W PINE ST			
16a WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) NO			16b SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES)		17 INFORMANT ADDRESS IVA SHORT BOOTH Gtwn DE				
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Acute Cerebral Thrombosis</u> 4340 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Generalized atherosclerosis</u> (c) <u>Due to, or as a consequence of</u>								APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 1 wk. yrs.	
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)									
19a DATE OF OPERATION			19b CONDITION FOR WHICH OPERATION WAS PERFORMED			20a AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19			21c HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)			
21d INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>			21e PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)			21f LOCATION STREET CITY OR TOWN COUNTY STATE			
22a I certify that (I) (this hospital) attended the deceased from <u>10/15</u> 19 <u>76</u> , to <u>4/10</u> 19 <u>80</u> , that (I) (we) lost saw the deceased alive on <u>4/9</u> 19 <u>80</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (If (we) (I) did not view the body after death)									
22b SIGNATURE <u>Earl M. Beardsley</u>			DEGREE MD			ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c DATE SIGNED 4/11/80	
22d PHYSICIAN'S NAME (TYPE OR PRINT) Dr. Earl M. Beardsley, M.D.			22e ADDRESS RT. 50& Civic Ave, Salisbury, Md. 21801						
23a BURIAL, CREMATION, REMOVAL (SPECIFY) BURIAL			23b DATE 13 APR 80		23c NAME OF CEMETERY OR CREMATORY ODD FELLOWS		23d LOCATION CITY OR TOWN COUNTY STATE LAUREL SUSS DE		
24 FUNERAL DIRECTOR NAME R. J. Doss			ADDRESS Gtwn DE			25a DATE REC'D. BY REGISTRAR APR 22 1980		25b REGISTRAR'S SIGNATURE [Signature]	

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

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STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

80

11311

1- FOR
STATE
REGISTRAR

REG. NO.

1 DECEASED NAME (TYPE OR PRINT) Maggie Adams WHEATLEY		2a DATE OF DEATH MONTH DAY YEAR 4-9-80		2b HOUR 2:15AM	
3 SEX F	4 RACE W	5 DATE OF BIRTH MONTH DAY YEAR 7-15-85		6 AGE (IN YEARS LAST BIRTHDAY) 94 YRS.	
7a BIRTHPLACE (STATE OR FOREIGN COUNTRY) Maryland		7b CITIZEN OF WHAT COUNTRY? U.S.		8 MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	
10 CITY OR TOWN OF DEATH Salisbury		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE RESIDENCE ADDRESS) Salisbury Nursing Home		12a USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Operator	
13a STATE Md.		13b CITY OR TOWN Sharptown		13c STREET ADDRESS Church Street	
14 FATHER'S NAME FIRST MIDDLE LAST Frank Wheatley		15 MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Tamsey Williams Wheatley			
16a WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No		16b SOCIAL SECURITY NO. 220-03-0497		17 INFORMANT ADDRESS Irving Wheatley Seaford, Del.	
18 CAUSE OF DEATH (Enter only one cause per item 18a and 18b) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Myocardial Infarction</u> 4340 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last (b) <u>Generalized arteriosclerosis</u> DUE TO, OR AS A CONSEQUENCE OF (c) <u>yes</u>					APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <u>1 wk.</u>
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)					
19a DATE OF OPERATION		19b CONDITION FOR WHICH OPERATION WAS PERFORMED		20a AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)	
21d INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f LOCATION STREET CITY OR TOWN COUNTY STATE	
22a I certify that (I) (this hospital) attended the deceased from <u>12/17</u> 19 <u>75</u> to <u>4/9</u> 19 <u>80</u> , that (I) (we) last saw the deceased alive on <u>4/8</u> 19 <u>80</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (If deceased died not within the body after death.)					
22b SIGNATURE <u>Earl M. Beardsley</u>		DEGREE <u>MD</u>		22c DATE SIGNED <u>4/9/80</u>	
22d PHYSICIAN'S NAME (TYPE OR PRINT) EARL M. BEARDSLEY, M.D.		22e ADDRESS Rt. 506 Civic Ave, Salisbury, Md.			
23a BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b DATE 4-12-80		23c NAME OF CEMETERY OR CREMATORY Eldorado Cemetery	
23d LOCATION CITY OR TOWN Eldorado, Dorchester Co., Md.		23e COUNTY STATE			
24 FUNERAL DIRECTOR Ulrich Funeral Home Sharptown, Md.		ADDRESS		25a DATE REC'D. BY REGISTRAR APR 21 1980	
25b REGISTRAR'S SIGNATURE <u>Jeffrey McCreedy</u>					

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